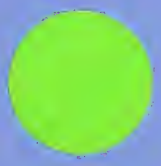
Health Care Financing Extramural Report

State Data Book on Long-Term Care Program and Market Characteristics, 1993

Health Care Financing Administration



Health Care Financing Extramural Report

The Office of Research and Demonstrations, Health Care Financing Administration, directs more than 300 intramural and extramural research, demonstration, and evaluation projects. These projects seek alternate ways to finance, organize, and deliver health services, as well as assess the impact of Federal programs on health care costs, providers, and beneficiaries. The Health Care Financing *Extramural Report* series represents the final reports from selected extramural projects funded by the Office of Research and Demonstrations. The statements and data contained in each report are solely those of the awardee and do not express any official opinion of or endorsement by the Health Care Financing Administration.

State Data Book on Long-Term Care Program and Market Characteristics presents data on State long-term care program and market characteristics compiled from a series of separate surveys of State officials in 1983, 1986, 1989, 1993, and 1994. The data collected describe the differences in long-term care programs across the 50 States and the District of Columbia. Also addressed are data on five types of providers of long-term care services; certificate-of-need programs; and State Medicaid reimbursement methods and rates.

Health Care Financing

Extramural Report

State Data Book on Long-Term Care Program and Market Characteristics, 1993

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1993 STATE DATA BOOK ON LONG TERM CARE PROGRAM AND MARKET CHARACTERISTICS

INTRODUCTION

This book presents data on state long term care program and market characteristics compiled from data collected by researchers at the University of California, San Francisco, and Wichita State University under a cooperative agreement with the U.S. Health Care Financing Administration and the U.S. Department of Housing and Urban Development.

The data, compiled from a series of separate surveys of state officials in I983, I986, I989, I993, and 1994, were collected in an effort to describe the differences in long term care programs across the states. All surveys were conducted by telephone using structured questionnaires that requested specific information from state officials from the principal agencies responsible for such data. Where possible, actual reports and data were requested in an effort to verify survey responses. All states and the District of Columbia voluntarily participated in the study by providing data.

SECTION I -- A SUMMARY OF NATIONAL TRENDS

This section summarizes trends in long term care programs across the fifty states and the District of Columbia for the 1978-1993 time period. Data on five types of state-licensed providers of long term care services are included: (1) nursing home facilities (NF); (2) intermediate care facilities for the mentally retarded (ICF-MR); (3) other residential care (or board and care); (4) adult day care; and (5) home health care agencies. Data on certificate-of-need (CON) programs are also presented. Finally, data on state Medicaid reimbursement methods and rates are described. Definitions for terms used in the book are included.

SECTION II -- STATE DATA FOR 1993

This second section presents state by state statistical data for 1993, along with a detailed narrative description. The first half of the state information provides demographic data, description of provider supply (in the categories described in section one), and certificate-of-need information for 1993.

The second portion of the state data describes Medicaid reimbursement methods and rates. Free-standing and hospital-based nursing home average reimbursement rates and rate increases are shown, along with the reimbursement method, peer groupings, adjustments, inflation factor, minimum occupancy levels, case-mix adjustments, capital reimbursement methods, cost centers, and ancillary components. Average reimbursement rates and rate increases are also presented for ICF-MR, home health care, residential care if any, adult day care, and sub-acute care.

SUMMARY OF NATIONAL TRENDS

This first section summarizes the trends in long term care programs across the fifty states and the District of Columbia for the 1978-1993 time period. Data on five types of providers of long term care services are included: (1) nursing home facilities (NF); (2) intermediate care facilities for the mentally retarded (ICF-MR); (3) residential care (or board and care); (4) adult day care; and (5) home health care agencies. Data on certificate-of-need (CON) programs are presented. Finally, data on state Medicaid reimbursement methods and rates are described.

DEMOGRAPHIC TRENDS IN THE STATES

The demand for long term care services is growing with the increasing numbers of individuals who are aged and chronically ill. In 1990, there were about 32 million Americans who were age 65 and older. As the population ages and develops chronic illness, the need for long term care services including nursing home services increases.

The average aged population in the U.S. has been increasing rapidly. The aged population (65 and over) was 11 percent of the total population in 1978 but grew to 12.7 percent in 1993. The percent aged 85 and over increased from 1.0 in 1978 to 1.4 percent in 1993 in the total U.S. population. States show a wide range of ratios of aged population. Alaska has the lowest ratios of aged (4 percent aged 65 and over in 1993) while Florida had 19 percent aged 65 and over and Arkansas, Iowa, Pennsylvania, Rhode Island, and West Virginia had aged populations of 15 percent or more. States with the lowest ratios tended to be in the west and states with the highest ratios of aged were in the northeast or central region.

The state population estimates of age 65 and over are from US Census data. Data for age 85 and over are from Medicare enrollment files because they were considered more accurate than the Census data.

NURSING HOMES

The large state and federal expenditures for nursing homes have drawn the attention of policy makers and researchers to understand the market for nursing home services. The demand for nursing home beds has been growing with the aging of the population and many other factors. As the need for nursing home care grows, the nation's capacity to provide such nursing home care is the subject of concern. Data on nursing home trends for the number of facilities, beds, types of facilities, size, growth rates, and occupancy rates were collected for the period of 1978 through 1993.

Total Licensed Nursing Home Facilities

The number of facilities in the nation increased from 14,264 in 1978 to 16,959 in 1993. This represents a 19 percent increase in the 16 year period of 1978-1993 for the U.S. Most states had an increase in the total number of facilities between 1992 and 1993, although 14 states did show a slight drop in the total number of facilities.

Total Licensed Beds And Average Facility Size

The total number of combined skilled nursing and intermediate care facility beds in the states increased from 1.3 million to 1.74 million between 1978 and 1993, or a 33 percent increase during the 16 year period. Thus, the growth in the number of beds exceeded the growth in the total number of facilities. The total number of nursing home beds varies with the size of the state. California, the state with the largest population, has the largest number of nursing home beds (128,411 in 1993). Six large states have 35

percent of the total nursing home beds in the U.S. (California, Illinois, New York, Ohio, Pennsylvania, and Texas).

The average number of beds per facility increased from 92 beds in l978 in the U.S. to 102 beds in l993 (a 12 percent increase in size during the l6 year period). The northeastern region had the highest average bed size (122 beds) and the west had the lowest (90 beds). The states with the largest average size of facilities were New York, District of Columbia, New Jersey, Pennsylvania, and Maryland.

Growth Rates

The total change in the number of beds for the U.S. was 33 percent between l978 and l993. In each of the years examined, the overall bed capacity increased although the rate of increase fluctuated. Some states had higher percentage growth rates than others, such as Arizona, Florida, New Mexico, and North Carolina. Other states have low growth rates. The total number of nursing home beds increased by 53 percent in the south, 32 percent in the northeast, 23 percent in the north central, and 20 percent in the west.

Ratio of Beds Per Aged Population

The average for the U.S. was 53.4 beds per 1,000 aged 65 and over in l978. The average ratio remained stable at 53.0 per 1,000 aged 65 and over in l993. On the other hand, the average number of beds per 1,000 aged 85 and over dropped from 610 to 491 between l978 and l993 (20 percent). The trend was downward for every year during the period.

Nursing home beds per population varied by census region. The ratio was highest in the north central states throughout the period (mean of 69 beds per 1,000 aged 65 and over population in l993). The ratios of beds to aged 65 and over were higher in the northeastern states (mean 51 per 1,000) and in the southern states (mean 50 beds) than in the west (mean 40 beds).

Occupancy Rates

Data on nursing home occupancy rates across states are difficult to obtain from state agencies. In l978, the average nursing home occupancy rate for 25 reporting states was 90.3 percent. The average occupancy rates for the U.S. increased gradually to a high of 92.8 percent in l984 (46 states reporting), and then gradually declined again to 91 percent in 1992 and 1993 (32 states reporting).

Although the occupancy rates were generally high for nursing homes, states did show a wide range in rates. The lowest rates reported were 82 percent in Indiana, Missouri, Texas, and Utah in l993. On the other hand, some states had extremely high occupancy rates: New York reported 99 percent occupancy rate. Kentucky, Massachusetts, Mississippi, North Dakota, Rhode Island, and West Virginia had also had high rates in l993.

Occupancy rates are highest in the northeastern states (mean occupancy of 97 percent in l993). The north central states (90 percent) and in the south (91 percent) were higher than in the west (mean occupancy of 88 percent). Nursing home occupancy rates were negatively correlated with the ratio of beds per population aged 85 and over in 1993.

The wide variation in occupancy rates suggests that some states may have an oversupply whereas others may have an undersupply of beds. Of the total states reporting in l993, 11 had occupancy rates at less than 90, 14 had occupancy rates between 90-95 percent, and 7 percent of the states had rates at 96 percent or greater.

COMMUNITY-BASED LONG TERM CARE SERVICES

Considerable growth in home care and other community-based long term care services occurred during the l980s, so that those who need long term care services have greater choices and expanded opportunities for public funding for such programs. As the number of community-based services has dramatically increased during recent years, this could have some effect in lowering the demand for beds by providing substitute services. Perhaps, these alternatives have grown in certain geographical regions in response to the limited availability of nursing home services.

Although it is clear that the demand for long term care services is growing, little is known about the availability of community-based long term care providers. Data on the current availability of licensed long term care services were collected from the fifty states and the District of Columbia in l993. Specifically, the services examined include intermediate-care facilities for the mentally retarded (ICF-MR), residential care, home health care, and adult day care services.

Intermediate Care Facilities for the Mentally Retarded

In 1993, 6,296 licensed ICF-MR facilities were identified in the states. The largest number was reported in New York (1,158 facilities). Texas, California, Michigan, Louisiana, Ohio, and Minnesota also had large numbers of facilities relative to those reported by other states.

There were 136,697 licensed ICF-MR beds in the states in 1993. The number of licensed ICF-MR beds increased less than one percent between l992 and l993. New York also had the largest number of beds (17,383 beds), but its beds declined by 1,307 beds or 7 percent over its numbers in 1989. Texas had the second highest number of beds (14,765 beds).

The average number of beds per facility was 22 beds in 1993. New Jersey, Maryland, and Oregon had the largest average number of beds per facilities, probably because of some large state ICF-MR facilities. ICF-MR facilities in Massachusetts, Vermont, and the District of Columbia facilities were the smallest compared with those in other states. The US average number of beds per facility appeared to be declining, but this varied considerably across states.

The average ratio of ICF-MR beds was .5 beds per 1,000 total population. As with nursing homes, ICF-MR beds per population varied by state. The highest ratios of ICF-MR beds per 1,000 total population were in Louisiana (1.5), Minnesota (1.3), and the District of Columbia (1.3). The lowest ratios were in Virginia, New Hampshire, Arizona, and Massachusetts.

Generally, states were unable to report occupancy rates for ICF-MR facilities. For those states reporting (25 states), the average occupancy rate was 94 percent in 1993. With the low ratios of beds per population, it was not surprising that occupancy rates were high. Again states varied considerably with Delaware reporting 100 percent occupancy and 13 other states reporting 95 percent or higher. On the other hand, Maryland reported a 69 percent occupancy rate in 1993.

Other Residential Care for the Aged

All states licensed some residential care (other than nursing homes), depending upon each state law. These included facilities such as board and care, foster care, and/or assisted living facilities.

There were 39,080 licensed residential care facilities reported for the aged in 1993. This was a 12 percent increase in the number of facilities between 1992 and l993. The states with the largest number of facilities were California (8,864), Michigan (4,876), Florida, Oregon, and Minnesota.

The total number of licensed residential care beds for the aged in the U.S. was 642,601 in 1993. This was a 5 percent increase over the 610,880 licensed board and care beds serving the elderly in 1992. California reported 145,846 beds, or twice as many as Florida (61,885), 4 times as many as New York, and 13 times as many as Texas.

The average number of licensed residential care beds per facility was 16 beds in 1993. States ranged widely in terms of the average size of facilities from 123 beds per facility in Indiana to 3 beds in Delaware.

The US average ratio of licensed residential care beds serving the elderly was 20 residential care beds per 1000 population aged 65 and over. These ratios also varied widely across states, from 46 beds per population in Virginia and 44 per population in California to 4 beds in Delaware.

Home Health Care Agencies

There was a total of 10,084 licensed home health agencies in the U.S. in 1993. Eleven states did not license agencies in l993. Florida had the highest number of licensed agencies (1,309). Texas, California, and New York also have large numbers of licensed agencies.

The average ratio of licensed home health care agencies per 1000 population aged 65 and over was 0.4 in 1993. Minnesota had the highest ratio. Virginia and New Jersey had low ratios.

Adult Day Care Centers

Twenty-seven states reported 2,131 licensed adult day care centers in 1993 in the U.S. This was an increase of over 41 percent over the number of centers in l992. Twenty-four states, however, did not license adult day care centers in l993. California reported the largest number of day care centers (555 in 1993). When the number of centers was compared with population aged 65 and over, the national average ratio was 0.10 per 1,000 aged population in 1993. Louisiana had the highest ratio of day care centers per population and Utah and Oklahoma had the lowest ratios.

Summary

The total number of ICF-MR beds remained stable. The number of residential care facilities, home care agencies, and adult day care programs is increasing in the recent time period. The large numbers of available providers shows these services are important components of the long term care delivery system. It is expected that these programs provide alternatives to nursing home services, and may reduce the demand for nursing home care. The wide variations of all types of LTC programs reflect the many historic differences in state programs and utilization patterns. Since there are also wide variations in the ratios of nursing home services across states, it is not surprising that other LTC services also vary across states.

CERTIFICATE OF NEED AND MORATORIA

State certificate-of-need policies are designed to limit bed stock. The first health planning efforts in the United States began in 1946 with the enactment of the Hill-Burton Act. Congress passed the National Health Planning and Resources Development Act of 1974 (P.L. 93-641) which established the certificate-of-need program (CON), which required approval for new beds and services. After the federal requirements for health planning and certificate of need were removed in l986, there was greater variation in state CON activities, where some states retained their programs and added moratoriums and others removed all CON requirements.

CON for Nursing Homes

By 1980, all states had adopted CON programs. After Congress failed to reauthorize the health planning legislation in the early 1980s and later passed the legislation repealing P.L. 93-641 in 1986, some states began changing their policies. Arizona eliminated its program in 1982, Idaho in 1983, Minnesota and New Mexico in 1984. In 1985, Kansas, Texas, Utah, and Wyoming all eliminated their CON programs. In 1987, California and Colorado joined these states in eliminating CON. South Dakota eliminated its program in 1988. Between 1989 and 1992, 41 states (including the District of Columbia) continued their CON programs for nursing homes. In 1993, Maryland dropped its CON program leaving 40 states with CON. Most of the states which eliminated their CON programs were in the western region of the U.S.

Nursing Home Moratoria

Some states began adopting nursing moratoria on all bed growth in the early 1980s. During 1980, Kentucky and South Carolina were the two states with CON programs which also reported adopting a moratorium on nursing home beds. After eliminating their CON programs, some states instituted a statewide moratorium on new nursing home beds and facilities. Several states which retained their CON programs also added a moratorium on nursing home beds and services during the 1980s. In 1993, five states had a moratorium without a CON program and 12 states with CON also had moratoriums. Thus, 44 states were regulating the growth of new nursing home beds and/or facilities through either a CON and/or a moratorium in 1993.

Of the 39 states with CONs for nursing homes, 36 had CON requirements for any conversion of hospital beds to nursing home beds in 1993. Of the 17 states that had nursing home moratoriums, 14 also had moratoriums on the conversion of hospital beds to nursing home beds.

CON for Other LTC Facilities

Many states that had CON programs for nursing homes also used CON for other long term care programs. Intermediate care facilities for the mentally retarded (ICF-MR) are also regulated under CON by a majority of states. In 1993, 28 states reported having CON requirements for ICF-MRs. Three states had moratoriums as well as CON for ICF-MR beds and facilities and 3 states had moratoriums without CON. Thus, 31 states were regulating ICF-MR facilities with CON and/or moratoriums in 1993.

Surprisingly, 10 states included residential care facilities under their CON legislation in 1993. Of these 10 states, 7 had CON only, 2 had both CON and moratoriums, and 1 had a moratorium only. For adult day care, 4 states had CON, 1 state had CON and a moratorium, and 1 had a moratorium only.

CON for Home Health Agencies

CON has gradually expanded to include home health care agencies in about half of the states. In 1978, 15 states had CON programs for home health agencies. Fourteen additional states added CON for home health between 1979 and 1981. Eight states dropped CON during the 1978-1993 period, but 2 were reestablished. Twenty states never adopted CON during the 1978-1993 period. In 1993, 23 states used CON for home health and 4 of these states also placed home health agencies under a moratorium.

CON Program Characteristics

Each state with CON and/or a moratorium is able to establish its own program criteria since the programs are established under state statutes. State criteria vary considerably in terms of when a CON is required. The need for a CON is typically based on the capital expenditure thresholds, equipment expenditure thresholds, the addition of a new service at a facility and/or an increase in the number of beds. The trigger

point for new service reviews is generally any new bed (in 26 states in 1993) or four or more new beds (9 states). Service thresholds for CON for long term care services ranged from $300,000 or more in Vermont to $4 million or more in Hawaii and Nevada.

The factors that trigger the need for a re-review of an existing nursing home CON also vary across states. Most states require a re-review whenever there is a change of ownership, a site change, a cost overrun, and/or a construction time overrun. Most state CON programs also specify the time period when construction must begin and the time when construction must be complete. The criteria for making decisions on applications varied by state. Thirty states used a methodology for decision making which considered facility occupancy rates and 31 states considered bed ratios within geographical areas.

CON Applications and Denials

One measure of the productivity of state CON programs is the number of applications reviewed. Some states had unusually large numbers of applications. Florida consistently had the largest number of CON applications, with 128 applications in l993. The total number of applications in the US declined from 1,540 in 1982 to 664 in l990 and then increased to 720 in 1993. The lower volume after l985 reflected the decline in states that had a CON program.

The average denial rate of the total applications was 23 percent in 1993. Florida with its high application volume had high denial rates (51 percent in l993). Kentucky had a high denial rate (50 percent in l993). North Carolina, Georgia, Missouri, and Tennessee also had fairly high denial rates.

CON Dollar Volume of Applications and Denials

The total dollar application volume was $1.9 billion in 1982 (for the 50 states reporting). This declined to $487 million in 1992 and then increased to $1.5 billion (33 states) in 1993. Florida had total dollar volumes of applications of $519 million in 1993. Alaska, Massachusetts, New Jersey, North Carolina, and Ohio had higher dollar application rates than most other states. Florida and North Carolina had the highest percentages of denials in terms of CON dollar value.

The percent of the dollar value of nursing home CON applications that were denied were collected from each state. The percent of the dollar value denied was highest in 1986 (33 percent) and declined to 29 percent in 1993 for those reporting states. The total CON dollar value of the applications which were denied declined from a high of $1.1 billion in 1986 to $443 million in 1993.

Relationship of CON/Moratorium To Selected Outcomes

The number of years that a state had a CON or moratorium in place was found to be associated with selected outcomes. A correlation analysis found that the number of years a CON program was in place between 1978 and 1993 was negatively correlated with the growth in beds in states during the period. The nursing home occupancy rates in states were positively associated with the years that states had CON or a moratorium in place. These findings suggest that states with more years of CON or moratoriums had less bed growth and higher occupancy rates.

Summary

In spite of the federal withdrawal of support for the CON program, the majority of states and the District of Columbia (39) retained their CON program and 17 states had moratoriums for nursing homes (12 states had both). Thirty-one states used CON and/or moratoriums for ICF-MR facilities and 10 used CON and/or moratoriums for residential care. Six states used CON and/or moratoriums for adult day care and 23 states used it for home health care. The CON programs varied across states in terms of their criteria for

project review and the total number of applications and denials. A sharp decline in the number of applications submitted and the number approved occurred during the 1982-1990 period, but applications increased to 720 in I993. The denial rate for applications was 23 percent in I993. The dollar volume of applications increased to $1.5 billion in I993 and the denial rate was $443 million in 1993. Thus, states are continuing to be active in regulating the growth in long term care services using CON and moratoriums.

MEDICAID REIMBURSEMENT RATES

State Medicaid reimbursement rates and methods have important effects on nursing home supply, demand, and access. State Medicaid programs attempt to control the growth in nursing home reimbursement rates, but are simultaneously concerned with such issues as access, quality, appropriate use of resources, and equity to providers. States have considerable discretion in their Medicaid reimbursement methods, and the consequent interstate variation is substantial. The resulting differences in provider revenues by state and region have important implications for the financial viability of nursing facilities and for access to and care in such facilities.

Primary data were collected in 1994 in telephone interviews about state Medicaid nursing home reimbursement rates and methods for Fiscal Year 1993 (I992-93). These data were added to earlier data for the I978-1992 period. This retrospective approach is different from, but complementary to the HCFA Medicaid spDATA System report, which presents data from state plans before implementation of the plans. Thus, these data show the reimbursement methods and rates that were actually used by states during the year.

Reimbursement Methods

Reimbursement methods are categorized into five groups: (1) retrospective, (2) prospective class, (3) prospective facility-specific, (4) prospective adjusted, and (5) combination prospective-retrospective. Retrospective methods have traditionally set rates based directly on the costs of providing care. Prospective methods set rates in advance, by using a flat rate for groups of facilities (class method), using rates for each facility based on historical costs and other factors (facility-specific method), or using rates for residents (also classified here as facility-specific). Adjusted methods are facility-specific but allow upward adjustments during a rate period, often based upon cost as data become available. They range from methods that allow a few upward adjustments a year to those that border on retrospective methods in the frequency and ease of adjustments. Because of a focus on a rate year, facility-specific methods that set rates more than once a year are also classified as adjusted. Combination systems use different approaches, sometimes for different cost centers, sometimes for different levels of care. An increasing number of states set case-mix rates, based upon the characteristics and/or special care needs of residents. Such methods can be applied to any of the general rate-setting methods; however, when class rates are made on the basis of the level of care for each resident, the rate paid to a facility depends on the blend of patient needs, so the system is classified as facility-specific.

Several state methods reported in the past were reclassified based on new information that included greater detail than previously available. Two states which had previously been reported as using class methods are reported here as facility-specific. These states blend statewide class rates by level of care, so that a given facility receives payment based on the actual levels of care needed by and provided to residents.

Several important changes occurred in reimbursement methods between FY 1992 and FY 1993, suggesting greater state concern with constraining costs while retaining flexibility. In particular, there was a pronounced shift away from less-stringent, combination (dropping from 5 to 3 states) toward facility-specific methods (increasing from 13 to 17 states), with no change in the number of states that use adjusted reimbursement systems. There was a decline in the use of class systems from 4 to 3 states.

Case-mix Reimbursement

Being classified as using case-mix reimbursement methods depends heavily upon a state's self-categorization, as well as upon judgments about the nature of a state's system. Consequently, two state's system not previously reported as a case-mix system arenow classified as case-mix.

Despite a recent rise in numbers of states with case-mix reimbursement, there was no change between FY 1992 and FY 1993 (19 case-mix states). Of the four states participating in the Health Care Financing Administration Case-mix Demonstration project, two implemented their systems starting in FY 1994, and the other two are slated to do so in FY 1995. Further, one state was to have re-established its case-mix system in FY 1994, and another plans to implement case-mix in FY 1995. Thus, within the next two years, half of all state Medicaid programs will be using case-mix reimbursement.

Cost Reporting Years

States use previous years' cost reports to set rates. In 1993, 38 states used cost reports from 1991 or later. The oldest cost reports were from 1983 (before providers had legal costs from Boren Amendment litigation which they initiated).

Ancillaries

The costs of ancillary services and/or products which are included in Medicaid reimbursement rates are not separately reimbursable. The inclusion of ancillaries in rates is important because facilities providing large amounts of ancillary services may be at financial risk, while those with low use of ancillaries may have costs below the amount "included" in the rate for the ancillary. Some implications are that: (a) the inclusion of an ancillary in the rate may be a financial disincentive for facilities to provide the ancillary service; (b) the inclusion of many, high-cost, and/or highly-varying ancillaries in rates may be a disincentive to the admission of Medicaid residents; and (c) some interstate variation in rates may be deceptive, unless the ancillaries included in the rates are considered.

Ten different types of ancillaries in nursing homes were identified in the Medicaid reimbursement rates for FY 1993. States included an average of about 6 of the 10 ancillaries in their per diem rates. Of three types of therapies, 26 states included all three, while 10 more included at least one, and only 15 states excluded all three therapies. Only 14 states included physician services. States were more likely to include disposable items; 48 states included medical supplies in rates, while 36 states included durable medical equipment. Most (44 states) included over-the-counter drugs in rates. One issue is whether prescription drugs are included in rates, because such medications can be high-cost, high-utilization and variable. Only two states included prescription drugs in rates in FY 1993.

Capital Component

Methods of reimbursing capital are highly complex as well as important. Historic-cost and market-value approaches may allow less control of changes in rates, by allowing greater inflation in valuation of capital. Some states address this by combining other approaches with historic-cost valuation. There was a slight shift back toward systems incorporating historic costs. In 1993, 25 states used historic costs and 16 used combination systems incorporating historic costs. Five states used rental value, one used market value, one used imputed values, and two used appraised value.

Reimbursement Rates

Medicaid nursing home per diem rates are the outcome of state reimbursement methods. Each state is characterized by one average rate. States with class methods may have no rate variation by geographical

or other groupings, but rates for other reimbursement methods vary around the average established rate. In consequence, estimating average per diem rates is complex. In class states, this involves averaging across groupings. In states with facility-specific or especially resident-specific methods, the process is more often an estimation than calculation, which is somewhat difficult and imprecise.

Medicaid per diem rates are not average Medicaid expenditures per day of care, because many Medicaid recipients pay a portion of the rate amount for their days of care, especially due to requirements to spend down to Medicaid eligibility. Thus, an average rate represents what is meant to be the average payment to a facility for a Medicaid day of care, only a portion of which may be actually paid by the Medicaid program. Such an average rate excludes additional charges not covered by the Medicaid program, such as the additional charge for a private room in a nursing facility.

The average Medicaid nursing home per diem reimbursement rates by state are reported for FY 1993. In l993, the average rate across states was $79.50 per day, which was about 4 percent higher than for 1992. To estimate an average U.S. rate, states were weighted by their numbers of nursing facility beds, resulting in an average of $76.25 in l993, compared to $73.11 for 1992. To allow for more meaningful comparisons, the rates were adjusted by the Consumer Price Index (CPI) to 1982-84 dollars for the entire 1978-93 period. The national mean of CPI-adjusted l993 rates was unchanged from the previous year ($52.30 in 1993 compared to $52.16 in l992). This is a change from the 1989-92 period, when rates were rising about 6 percent per year above inflation. It is also in contrast to the era before 1989, when rate increases were approximately two percent per year above inflation.

Summary

In summary, Medicaid nursing home reimbursement rates vary widely across states. State Medicaid reimbursement methods for nursing homes are gradually changing to facility specific methods and case-mix reimbursement systems. Most states include some ancillaries in their basic reimbursement rates. Capital reimbursement is largely based on historic costs. Reimbursement rates increased on average about four percent between FY l992 and l993 but when rates were adjusted for inflation, they remained stable during the past year.

OTHER MEDICAID LONG TERM CARE REIMBURSEMENT

Data were collected on five other types of care: ICF-MR, home health care, residential care, adult day care, and sub-acute care. The last three types of care are optional or waivered Medicaid services and therefore are not reimbursed under Medicaid in some states.

Intermediate Care for the Mentally Retarded

States can use the same options for reimbursing ICF-MRs as for nursing homes. In comparison to nursing facility methods, ICF-MR reimbursement methods are more likely to use less cost constraining methods. Ten states used retrospective methods, 11 states used adjusted methods, and 3 states used combination reimbursement methods in l993. Five states used the most-restrictive reimbursement system, i.e. the class methodology, and 18 used the prospective facility-specific method.

Home Health Care

States have a variety of ways to reimburse home health care agencies. States may opt to simply apply Medicare principles, which was used by 10 out of 48 reporting states in 1993. States may make state alterations to Medicare principles, as 12 states did. Paralleling nursing home reimbursement methods, states may set home health rates retrospectively (2 states), agency-specific prospective rates (2 states) or use flat rates on a fee-schedule (21 states). One other state computes both prospective and retrospective rates, and sets payment at the lower rate. Of 46 states reporting methods for both 1992 and l993, one-

third (15) reported changes in methodology, with no clear pattern of change. Most common (3 states) was the elimination of state alterations to Medicare principles.

Residential Care

Thirteen states provide Medicaid services to persons in residential care, generally under Section 1915c, 1915d, or 2176 waivers. Some programs are tied to specific types of clients -- e.g. the aged, physically disabled, mentally ill, or developmentally disabled. The types of facilities may be categorized as residential care, assisted living, foster care, group homes, and family homes.

Adult Day Care

Of the states reporting, 33 provide Medicaid coverage for adult day care, generally through waivers. Facility types range from social to day health care, to special programs for clients, such as programs for dementia and Alzheimer's clients. Client groups include the aged, pediatric, developmentally disabled, physically disabled, mentally ill, persons with AIDS/HIV, and substance abusers. Different rates are set for different client types in some states.

Sub-Acute Care

Thirteen states report covering nursing home sub-acute care services under Medicaid. Reimbursement rates may vary by the types of clients and services approved. These types may include residents receiving ventilator services, complex respirator services, special rehabilitation services, head trauma care, AIDS/ARC services or other complex health care. These special sub-acute rates are approved for skilled nursing services that are more intense than the traditional nursing facility services but less costly than general hospital services and rates.

Summary

States have wide discretion in establishing Medicaid rates for long term care services. The states historically used nursing home methods for ICF-MR and Medicare reimbursement methods for home health care. As the number and types of long term care services expand, states are developing more complex reimbursement systems for Medicaid payment. The variation in methods and rates is wide across states.

DEFINITIONS

Add-on Reimbursement Costs:	The procedure of incorporating additional costs that are beyond the normal rate setting methodology. These costs may be included in the rate calculation or be added to the calculated rate so that they actually affect the rate.
Adjusted Reimbursement Method:	A change in a rate upward during the rate year. For our purposes this can include more than one rate period during a year, even if the rates are not adjusted during those periods, or an interim rate. An actual change in the rate is required, not just a policy or provision that would allow it to be adjusted. The change in the rate does not always include all facilities within a given state.
ADL:	Activities of Daily Living are those activities for which individuals may require assistance from others, such as bathing, dressing, eating, toileting, and transferring. These activities needs are frequently used by states or programs in determining eligibility for long term care services.
Adult Day Care Facility:	A state-licensed adult facility that provides services for individuals on a part time and/or intermittent basis. Programs generally include health, social, personal care, and related supportive service in a protective setting to meet the needs of functionally or mentally impaired adults.
Adult Foster Care:	May be considered a type of residential care facility.
Ancillary Services:	A usually consistent (across states) set of services provided in the course of care in a nursing facility. They can be included in the rate under the appropriate cost center, billed separately, or paid by another program.
Appraisal/Reappraisal:	Formal estimation of the value of an asset in a nursing facility.
Assisted Living Facility:	May be considered a type of residential care facility.
Beds:	The total number of licensed beds in a facility at the end of the calendar year. This is used as a capacity measure of a facility.
Boren Amendment:	This legislation was passed in l980 to require states to reimburse Medicaid providers using rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilites." A number of nursing homes and their associations have filed lawsuits against states under the Boren Amendment.
Case-Mix Reimbursement:	Systems that require a method for assigning scores or "weights" to different residents, reflecting the relative costliness of caring for different residents, based on measurable characteristics (e.g., dependencies in activities of daily living). These weights are incorporated if rate setting is at the facility or patient level. Systems that pay different rates for different levels of care are classified here as having case-mix reimbursement.

Certificate-of-Need (CON):	State requirement that particular categories of health care providers must meet in order to receive approval to build new facilities and beds or to remodel or convert existing facilities, to add new programs or services, or to purchase new equipment. Each state may establish its own criteria for CON as well as monitoring and/or penalty procedures.
Class or Flat Reimbursement Method:	State designation of reimbursement method based on a uniform reimbursement amount and may be established for peer groups such as size or geographical region (class) or be a uniform (flat) across a state. The system is categorized as a class method only if the rate is same for all facilities in the class.
Combination Reimbursement Method:	Combination of rates set in advance (prospective) for some cost components and/or set afterward for others based on actual costs (retrospective).
Capital Costs:	The portion of the per diem rate that includes costs associated with construction, acquisition or lease of land, buildings or equipment used for resident care in a nursing home.
COBRA:	Consolidated Omnibus Budget Reconciliation Act of 1985. This legislation "Added new capital provision allowing state Medicaid programs the latitude to grant a more generous step-up upon a change of ownership if they so desired. Under COBRA, for transfers on or after October 1, 1985, the valuation of the facility can increase over that allowed under DEFRA by one-half the percentage increase in the Dodge Construction Index or Consumer Price Index, which is lower, measured from the date of acquisition by the seller to the date of the change in ownership. COBRA allowed an inflation adjustment of asset basis upon a change of ownership. COBRA is not mandatory. Programs can continue to impose the DEFRA limitations." (Lubarsky 1993)
Cost Centers:	Categories (set individually by state) of costs usually used for rate delineation such as in case-mix as well as for cost finding and rate calculations. Specific cost center categories may be set for nursing care, administration, or others areas, or may be a more inclusive category cost center such as for direct or indirect care. These are generally used to apply a limit or cap to an area of expenditure, but approaches vary. Some systems apply limits differently to components within what are considered the same cost center.
Cost Report:	Facility specific cost reports which are used to calculate and set policy for reimbursement. Usually includes allowable costs, non allowable costs, and aggregate patient information.
Cost Report Year:	Fiscal year of cost report used in setting a reimbursement rate.
DEFRA:	Section 2314 of the Deficit Reduction Act of 1984 which "added provisions that limited adjustments upon a change of ownership to the historical cost of the owner of record of a facility as of July 18, 1984. Medicaid will pay for the use of an asset only once. Many state Medicaid

	programs do not have depreciation recapture provisions. As such, some of these state have utilized DEFRA to impose a more stringent limitation upon an ownership change by not allowing any step-up whatever, not even to the seller's historical cost. In this case, the buyer's basis for depreciation and interest would be the seller's net book value. DEFRA does not preclude states from utilizing alterative methods of capital payment, such as fair rental approaches." (Lubarsky 1993)
Domicillary Care:	May be considered a type of residential care facility.
DRGs:	Diagnosis Related Groups are used as the basis for the Medicare prospective payment system for hospital reimbursement.
Equity:	The difference between appraisal value and property debt. (Lubarsky 1993).
Fair Rental System:	An equitable system for calculating a capital per diem rate, irrespective of cost. It is based on a gross, net or modified method of facility value which can increase with inflation and building upkeep.
Facility-specific Reimbursement Method:	State designation of reimbursement method based on facility characteristics, costs, or patient characteristics. This method may be for only a portion of the total reimbursement rate.
Free-standing Facility:	A nursing home facility not attached physically to a hospital.
Historic Cost:	Method for acquiring an asset such as a nursing facility less discounts plus all normal incidental costs necessary to bring the facility into existing use and location.
Hospital Based Facility:	A nursing home facility that is attached to a hospital.
Home Health Care Agency:	Agency which may be licensed by the state to provide nursing, therapy, personal care, and/or other services in an individual's home or in the community. States may develop their own criteria for licensing which may be different from the federal criteria for certification to provide Medicare and/or Medicaid services. Some states do not require licensure but certify agencies to provide Medicare/Medicaid services under the federal guidelines.
ICF:	Intermediate care facility. Under the implementation of OBRA in 1990, these facilities became "nursing facilities" or "Nfs." The designation of ICF is used by some states to indicate the level of care needed for residents as opposed to the classification of the facility.
Interim Rate:	A temporary prospectively set per diem rate paid during a rate period that is then retroactively adjusted when final cost and other needed data are available. If an interim rate is fully adjusted to costs, the system is classified as retrospective; if the rate is not fully adjusted to costs, it is classified here as prospective.

ICF-MR:	Intermediate care facilities for the mentally retarded (ICF-MR) are state licensed facilities that provide 24-hour care and supervision to persons who can benefit from active treatment. Generally health, social, personal care, and related supportive services are provided in a protective setting to meet the needs of functionally and/or mentally impaired individuals.
Imputed Value:	Cost that is implied. In the case of nursing home reimbursement it is a value reached by a mathematical formula and is generally a composite of different costing methods or calculations.
Limit/Cap:	Method of constraining costs, usually of a particular Cost center. It can be a percentile of a median, fixed rate such as found in capital cost, an occupancy rate, etc.
Market Value:	Typically, the price at which an item could be sold.
Medicaid:	Title XIX of the Social Security Act, commonly known as the Medicaid Act, 42 USCA 1396-1396, creates a cooperative relationship between the federal government and states that elect to share the medical expenses of persons who have limited financial resources.
Medicaid Resident Days in Percent:	The total number of Medicaid resident days in a nursing home divided by all resident days in the nursing home, expressed as a percentage.
NNHIPI:	National nursing home input price index.
Nursing Home Facility (NF):	A state licensed facility providing skilled nursing and/or intermediate care services to individual residents on a 24 hour basis. This category was created by OBRA I987 Nursing Home Reform legislation.
OBRA, 1987:	The Omnibus Reconciliation Act of 1987. This legislation included Nursing Home Reform legislation. Provisions were made that "Facilities must meet certain requirements, or conditions of participation, for professional staffing, provision of services, facility standards, administrative management and other health and safety standards that may be prescribed by the Secretary. These requirements include the maintenance of policies governing the administrative and medical procedures of the nursing facility and safeguards to assure quality of care and protect residents' rights." "The OBRA '87 requirements revise the conditions of participation for nursing homes, the process for monitoring compliance with the law, and the remedies available to Federal and State agencies in the event of noncompliance. The provisions require nursing facilities to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This outcome is to be achieved through a resident assessment coordinated with an individualized plan of care reviewed annually. These vehicles for achieving and assessing quality of care replace the existing Inspection of Care process." The legislation also required "Survey agencies monitor the performance of facilities by determining whether they comply with the Federal conditions of participation." Procedures for states in the overall operation of the survey and certification program are

	contained in regulations and administrative guidelines were developed and implemented at various points after the legislation was adopted.
Occupancy Rate:	The average daily census of facility residents compared to the total number of licensed beds, expressed as a percentage.
Pass-through:	Costs that are outside the structure of the rate calculating procedure and will remain outside, so have no direct effect on the per diem rate.
Personal Care:	May be considered a type of residential care facility.
Prospective Payment:	Rates set in advance of payment.
Peer Groupings:	Groupings of cohorts used in the rate setting process of nursing facilities. Groups types may be by size of facilities, ownership, geographic location (Urban/Rural, County, Region, etc.) or other categories which can be a ceiling or combination of groupings defined within a state system.
Rate Year:	Specific time period for an established rate, which may: be a calendar year for states or facilities; concide with the federal fiscal year (starts October 1); be a state fiscal year (usually starts in July or September); or be a facility fiscal year (starting and clustering at more than one month with in a year).
Rate Period:	Length of time a rate is in effect. This can be an annual, semi-annual, or a state-specific period (e.g. a quarter).
Rebase:	Updates or changes to the basic data on which the calculations are made for arriving at reimbursement rates.
Rental Value:	Cost to lease an item of property.
Replacement Costs:	Current cost to replace property in a particular geographic area.
Replacement Value:	Current cost to replace the service potential of an existing asset. The emphasis is placed on obtaining an asset with identical future service capabilities, which is also another definition of replacement costs.
Resident-specific Reimbursement Method:	State designation of reimbursement method using calculations based on individual resident characteristics/costs, as in a case-mix system. This approach may be used for all or for only a portion of the total reimbursement rate.
Residential Care Facility:	A facility which provides services to individuals not requiring skilled nursing care. Services are provided on a 24 hour basis and generally include supportive care services and supervision for those who are physically and/or mentally impaired. These may include board and care, foster care, family homes, group homes, domicillary care, or other types of facilities. States develop their own criteria for licensure or non-licensure for different types of facilities and states have their own definitions and names for facility categories.

Retrospective Reimbursement Method:	Payment is determined after services are rendered, based on actual costs. Interim rates are used and then the final rates are adjusted to cover actual costs when cost data are available.
RUGs:	Resource utilization groups are categories developed to classify residents based upon the amount of personnel resources used to provide care for those residents
Sheltered Care:	May be considered a type of residential care facility.
SNF:	Skilled nursing facility. Under the implementation of OBRA in 1990, these facilities became "nursing facilities" or "Nfs." This designation is retained by some states to characterize the level of care needs of residents rather than the classification of the facility.
Subacute Care:	Nursing home services offered 24 hours either in hospitals at a level less intensive than acute inpatient services, but more intensive than Medicaid nursing facility care. These services may be offered in special care units or integrated within general units. They may focus on short-term, intermediate, or long term care nursing services, and may be licensed as general hospital beds, swing beds, or nursing home beds. Hospital subacute care not provided in licensed nursing facility beds are not included in this report.
Swing Beds:	Acute care hospital beds that may be used to provide skilled nursing care to patients on a temporary or part-time basis. Facilities are generally paid a Medicaid reimbursement rate below that paid for acute hospital care.
Traditional Capital Reimbursement Method:	A system for calculating capital per diem rate based on cost which is usually subject to controls.
Waiver Services:	Medicaid legislation allows states to provide special services under specific waiver provisions. Section 2176 of P.L. 97-35 (OBRA 1981) added Section 1915 to the Social Security Act to allow for home and community-based waiver services. COBRA (I985), OBRA (1986), OBRA (I987), and OBRA (1990) all added new sections for waivers.

STATE PROFILES

ALABAMA

Nursing Homes

The number of nursing homes in Alabama has been growing modestly, increasing from 189 in 1978 to 224 in 1993. The number of beds has shown a similar increase, from 19,879 in 1978 to 23,363 in 1993. The ratio of licensed nursing home beds per 1000 population aged 65 and over was 42.9 in 1993, compared to a U.S. ratio of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has remained constant at 8 since 1989 while the number of beds has been slowly decreasing, from 1,350 in 1989 to 1,208 in 1993. The 1993 ratio of beds per facility was 151.0, one of the highest ratios in the country.

Other Residential Care

Alabama licenses residential care in assisted living facilities. The totals of these facilities and beds have been slowly increasing, from 163 facilities and 3,464 beds in 1989 to 179 facilities and 3,993 beds in 1993.

Adult Day Care and Home Health Care

Adult day care is not licensed in Alabama. Home care agencies are not licensed but the number of certified home care agencies has been slowly growing, from 118 in 1989 to 155 in 1993.

CON/Moratorium

Alabama had a CON for nursing homes from 1978 through 1993, adding a moratorium to in 1984 through 1989 and again in 1993. In 1993 the CON/moratorium also covered hospital bed conversion and home health care, while there was neither a CON nor moratorium on ICF/MRs or residential care. There were 57 CON applications for nursing homes in 1993, only 1 of which was denied.

ALABAMA

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	224
Total Beds	23363
Beds Per Nursing Home	104.3
Average Occupancy Rate	95.8
Beds Per 1000 Population:	
Age 65 and Over	42.9 (US 53.0)
Age 85 and Over	398.2 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.99 (US 6.2)
Expenditures Per 1000 Pop, 1992	$75,398 (US $92,314)
Adequacy of Bed Supply	Under Supply

Intermediate Care For Mentally Retarded

Total Facilities	8
Total Beds	1208
Beds Per Facility	151
Beds Per 1000 Population	0.29 (US 0.53)

Other Residential Care For Aged

Total Facilities	179
Total Beds	3993
Beds Per Facility	22.3
Beds Per 1000 Pop, Age 65+	7.33 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.29 (US 3.6)
Expenditures Per 1000 Pop, 1992	$12,484 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON & Moratorium
Day Care Agencies	No CON nor Moratorium

ALABAMA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid facility-specific nursing facility rates. The method employs peer groupings by number of beds and ceilings broken down within cost center categories. The basic reimbursement method was adopted in 1991. Rates were based on a facility fiscal year beginning July 1. The rate period was set annually and rebased in 1992 for 1993, using the cost report ending June 30, 1992. Inflation was based the DRI (Market Basket Index of Operating Costs-Skilled Nursing Facility). No minimum standard for occupancy was used to set the reimbursement rate in Alabama.

Adjustments

Adjusted. The rates were adjusted upward during FY93 two times; with all facilities included in the adjustment. Facilities were audited at least every five years.

Cost Centers

Alabama uses four cost centers: 1. Operating, ceiling 110% of the median; 2. Direct Care, ceiling 120% of the median, then capped at an additional 10%; 3. Indirect Care, ceiling 110% of the median; and 4. Property.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, Patient Transportation, Dental Consultant, and Oxygen Machines were included in the rate. Ancillary Services were cost based and rolled into the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Alabama. They employ a single level of care.

Capital Costs

The Value of capital was determined by a Rental Value. The Fair Rental systems present maximum for new beds was $26,522.50. This amount was re-based to no more than three percent. Gross Rental Factor was 2.5%.

Reimbursement Rate

The 1993 average reimbursement rate for Alabama was $71.91 by median.

Other Long-Term Care

Alabama uses the same system for hospital-based as for free-standing nursing facilities. However, it reimburses ICF-MR using a prospective class system, and its average reimbursement is almost three times that for nursing facilities. Home health agencies are reimbursed using Medicare principles, but with state alterations, including flat rates for RN and for home health aide services that were set at the same $27.00 per visit in I993. Alabama Medicaid does reimburse under waiver for other residential care for the aged and for adult day care, both using retrospective services.

ALABAMA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$71.91
Percentage Rate Change From Previous Year	15%
Peer Groupings	Number of Beds and Ceilings
Year of Cost Report to Set Rate	1992
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None (one level of care)
Capital Reimbursement Determination	Rental Value
Ancillary Services Included in Rate	Medical Supplies, Patient Transport, Dental Consultant, Oxygen Machines, Non-Prescription Drug

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Class
Ancillary Services	Covers All Ancillary Services
Average Reimbursement Rate	$196.33
Capital Reimbursement Determination	Same as Free-Standing Nursing Facilities, but No Rental Value

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$27.00 (flat rate)
Average Reimbursement Rate, HH Aide Visit	$27.00 (flat rate)

Other Residential Care For Aged

Method	Retrospective Facility-Specific
Program	1915c Waiver
Average Rate	
Foster Home	$20.00 (approximate)
Group Home	$37.00
Residential Care	$41.48

Adult Day Care

Method	Retrospective, Contract Negotiation
Reimbursement Program	1915c Waiver
Average Rate by Service Offered	
Day Health	$12.22-$13.29/Hour
Clients Covered	Aged & Disabled

Sub-Acute Care

No Separate Program

ALASKA

Nursing Homes

The number of nursing homes in Alaska has remained relatively constant, increasing from 18 in 1978 to 22 in 1993, the second fewest nursing homes in the country. The number of nursing home beds increased from 923 in 1978 to 1,033 in 1993 - the fewest nursing home beds in the country and a ratio of 39.2 beds per 1000 population aged 65 and over (compared to a national average of 53.0).

Intermediate Care for Mentally Retarded

There have been 2 ICF/MR facilities (each with four "cottages") with a total of 104 beds since 1990. The average number of beds per facility is 52.0, over 2 times the national average. The ratio of ICF/MR beds per 1000 population in 1993 was .17, low compared to the U.S. average of .53.

Other Residential Care

Alaska licenses two categories of residential care - foster care, with 5 or fewer beds, and residential care, with six or more beds. In 1993 the total number of facilities was 125, an increase of 35 facilities since 1992. The total number of beds increased during this year from 495 to 707.

Adult Day Care and Home Health Care

Adult day care is not licensed in Alaska. The number of home care agencies is small (13 in 1993) but is slowly increasing.

CON/Moratorium

Alaska had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. There were no CON applications for nursing homes in 1993.

ALASKA

Demographics

Percentage Population 65 and Over	4.4 % (US 12.7%)
Percentage Population 85 and Over	0.3 % (US 1.4%)

Nursing Home Facilities

Total Facilities	22[1]
Total Beds	1033[1]
Beds Per Nursing Home	47
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	39.2 (US 53.0)
Age 85 and Over	578.7 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.83 (US 6.2)
Expenditures Per 1000 Pop, 1992	$64,902 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	2[1]
Total Beds	104[1]
Beds Per Facility	52
Beds Per 1000 Population	0.17 (US 0.53)

Other Residential Care For Aged

Total Facilities	125
Total Beds	707
Beds Per Facility	5.7
Beds Per 1000 Pop, Age 65+	26.83 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	13
Agencies Per 1000 Pop, Age 65+	0.49 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.1 (US 3.6)
Expenditures Per 1000 Pop, 1992	$6,756 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

ALASKA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer grouping within free-standing facilities. The basic reimbursement method was adopted July 1, 1989. Rates were set and rebased annually by facility year end, clustering in June and December. The 1990 cost report was used to determine rates for the routine portion. Inflation based on the DRI, influenced by state data, was used to trend rates for the base year operating expenses less capital. A minimum occupancy standard was not used in setting the reimbursement rate for FY93.

Adjustments

Adjusted. An upward rate adjustment during the rate period was made for thirty percent of Alaska's facilities (four out of thirteen).

Cost Centers

Three inclusive cost centers were used for reimbursement in Alaska: Routine, Ancillary, and Capital. No limits were applied for FY93.

Ancillary Services

Ancillary Services are a separate cost center. Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Patient Transportation were included in the rate. The Ancillary Cost Center rate is built into the rate, calculated from the base year costs.

Case-Mix Adjusters

No case-mix adjusters are used in Alaska. Their system provides for a single level of care.

Capital Costs

The value of capital was determined by historic cost. Capital-interest expenses are valued by the actual interest expense. The maximum allowable interest was not capped for FY93. Capital costs include interest, depreciation, insurance on property, plant and equipment, leases and rentals for real property exclusive of equipment, amortization of capitalized loan improvements and amortization of startup organization and abandoned planning costs amortized over a period of 60 months. Alaska uses straight line depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for Alaska was $221.27, calculated by days of care. The Routine portions was $163.74, Ancillary $19.91, and Capital $37.62.

Other Long-Term Care

Alaska uses the same system for hospital-based as for free-standing nursing facilities. Although it also reimburses ICF-MR using this same system, its average reimbursement is over 50% higher than that for nursing facilities. Home health agencies are paid 80% of their submitted charges. Residential care for the aged, adult day care, and sub-acute care are not reimbursed by the Alaska Medicaid Program.

ALASKA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$221.27
Percentage Rate Change From Previous Year	1.87%
Peer Groupings	None
Year of Cost Report to Set Rate	1990
Inflation Adjustment	DRI, Influenced by State Data
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies
Durable Med. Equip.	Patient Transport
Non-Prescription Drug	

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

IFC-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$343.41

Home Health

Method	Pay 80% of Submitted Charges
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care for Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

ARIZONA

Nursing Homes

The number of nursing homes in Arizona more than doubled between 1978 (67 facilities) and 1993 (148 facilities), while the number of beds tripled from 5,354 in 1978 to 16,444 in 1993. The 1993 ratio of beds per 1000 population aged 65 and over was 31.1, low compared to the U.S. average of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities grew from 9 in 1990 to 12 in 1993, with an increase of 209 beds (from 106 to 315) over the same period. The ratio of ICF/MR beds per 1000 population in 1993 was .08, the third lowest ratio in the country.

Other Residential Care

Residential care was not licensed in Arizona before July 1992. There were 562 residential care facilities in 1993, 290 licensed, the others pending licensure.

Adult Day Care and Home Health Care

Adult day care increased in Arizona from 13 facilities in 1989 to 37 in 1993. The number of licensed home care agencies increased from 102 in 1991 to 127 in 1993.

CON/Moratorium

Arizona had a CON for nursing homes between 1978 and 1981, dropped it in 1982 and had neither a CON nor moratorium through 1993. In 1993 there was no CON or moratorium for hospital bed conversion, ICF/MRs, residential care, or home health care. There has not been a CON or moratorium for home health care for at least 15 years.

ARIZONA

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.2 % (US 1.4%)

Nursing Home Facilities

Total Facilities	148
Total Beds	16444
Beds Per Nursing Home	111.1
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	31.1 (US 53.0)
Age 85 and Over	350.2 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.48 (US 6.2)
Expenditures Per 1000 Pop, 1992	$3,797 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	12[1]
Total Beds	315[1]
Beds Per Facility	26.3
Beds Per 1000 Population	0.08 (US 0.53)

Other Residential Care For Aged

Total Facilities	562
Total Beds	5209
Beds Per Facility	9.3
Beds Per 1000 Pop, Age 65+	9.85 (US 19.6)

Adult Day Care For Aged

Total Facilities	37
Facilities Per 1000 Pop, Age 65+	0.07 (US 0.10)

Home Health Care Agencies

Total Agencies	127
Agencies Per 1000 Pop, Age 65+	0.24 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.54 (US 3.6)
Expenditures Per 1000 Pop, 1992	$160 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	No CON nor Moratorium
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

ARIZONA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, was based on facility-specific data. The rates themselves were categorized both as class and facility specific[1]. The method employs the peer grouping of geographic location (by county): Metro and Rural (overall rural, and special rural). The basic reimbursement method was adopted in 1989. Annual rates were set by a October to September, facility fiscal year for the Primary care component. Most facilities were on a calendar year. The 1991 cost report was used for 1993. The DRI was used to trend rates as well as regional wage indexes through a nursing facility market basket. The indirect and capital components of the rate were adjusted to reflect a minimum occupancy adjustment of 85%.

Adjustments

No adjustment was made other than the annual rate setting adjustment of the initial rates.

Cost Centers

Cost centers consist of Primary Care (nursing costs only), Indirect Care (non-nursing and non-capital), and Capital.

Ancillary Services

Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, and Durable Medical Equipment were included in the rate. These ancillaries were included in the calculation of the rate under the appropriate cost center.

Case-Mix Adjusters

Case-mix adjusters were used in Arizona. Four levels-of-care classes were employed, including ventilator and sub-acute patients (Class 4). Class 4 was based on negotiated rates and didn't exceed an aggregate monthly limit unless prior authorization was obtained. Three levels of care Classes were used in the Primary cost component only. It used the PAS, the Maryland time and motion study, and salary information based Arizona's nursing home industry. Rates were set on an overall basis. The Primary Care Portion was accounted for in Case-mix.

Capital Costs

Arizona used Historic Cost to determine the value of capital. Depreciation, interest, and rent from facility rate filings were used as the basis of the capital cost component which becomes a fixed statewide rate. For capital-interest expenses, nursing facilities used the actual interest expense. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for Arizona was $ 71.97.

Other Long-Term Care

Arizona uses the same system for hospital-based as for free-standing nursing facilities, but employs a combination system to pay for ICF-MR, with average rates over three-times that for nursing facilities. Home health agencies are reimbursed using a fee schedule that pays over twice as much ($45) for a RN visit as for a home health aide visit ($21). Arizona Medicaid reimburses under waiver for adult day care, using negotiated contract fees.

ARIZONA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$71.97
Percentage Rate Change From Previous Year	-0.46%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1991
Inflation Adjustment	DRI Market Basket & Regional Wage Indices
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	Acuity Measure, Primary Care is Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Respiratory Therapy, Durable Med. Equip., Non-Prescription Drug, Medical Supplies

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Combination Class
Average Reimbursement Rate	$244.00
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Included All Ancillary Services

Home Health

Method	Fee Schedule
Average Reimbursement Rate, RN Visit	$45.00
Average Reimbursement Rate, HH Aide Visit	$21.00

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Contract Negotiated Fee-For-Service
Program	1115 HCBS
Average Rate	$4.47/Hour
Facilities	Social, Day Health, Dementia/Alzheimer's Disease
Clients Covered	Aged, Physically Disabled, Mentally Ill, Developmentally Disabled

Sub-Acute Care

No Separate Program

ARKANSAS

Nursing Homes

The number of nursing homes in Arkansas increased from 210 in 1978 to 252 in 1986 and 1989. The number has been declining since then to a 1993 total of 237. The number of beds has been increasing, from 18,548 in 1978 to 24,306 in 1993. The 1993 ratio of nursing home beds per 1000 population aged 65 and over was 67.1, greater than the U.S. average of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities increased from 17 in 1989 to 41 in 1991 and then dropped to 40 in 1993. The number of beds showed a similar trend, increasing from 1,967 in 1989 to 2,209 in 1991 before dropping to 1,802 in 1993. There were .74 ICF/MR beds per 1000 population in 1993, substantially greater than the U.S. average of .53.

Other Residential Care

The number of residential care facilities in Arkansas has been slowly growing, increasing from 98 in 1989 to 108 in 1993. The number of beds increased from 2,609 to 3,917 during this period. The average number of beds per facility in 1993 was 36.3, about 2 times the national average.

Adult Day Care and Home Health Care

Arkansas had 20 licensed adult day care facilities in 1993, an increase of 2 from 1992. There were 215 licensed home care agencies and 185 certified home care agencies in 1993.

CON/Moratorium

Arkansas had a CON for nursing homes from 1978 through 1993. In 1987 and 1988, and again in 1992, a moratorium was added to the CON. In 1993 the CON/ moratorium also covered hospital bed conversion, ICF/MRs, residential care, and home health care. The CON for home health care began in 1981, with a moratorium added to it in 1987, 1988, and 1992.

ARKANSAS

Demographics

Percentage Population 65 and Over	15 % (US 12.7%)
Percentage Population 85 and Over	1.7 % (US 1.4%)

Nursing Home Facilities

Total Facilities	237
Total Beds	24306
Beds Per Nursing Home	102.6
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	67.1 (US 53.0)
Age 85 and Over	597.1 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.76 (US 6.2)
Expenditures Per 1000 Pop, 1992	$96,813 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	40
Total Beds	1802
Beds Per Facility	45.1
Beds Per 1000 Population	0.74 (US 0.53)

Other Residential Care For Aged

Total Facilities	108
Total Beds	3917
Beds Per Facility	36.3
Beds Per 1000 Pop, Age 65+	10.81 (US 19.6)

Adult Day Care For Aged

Total Facilities	20
Facilities Per 1000 Pop, Age 65+	0.06 (US 0.10)

Home Health Care Agencies

Total Agencies	215
Agencies Per 1000 Pop, Age 65+	0.59 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.74 (US 3.6)
Expenditures Per 1000 Pop, 1992	$18,668 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	CON & Moratorium
Home Health Care Agencies	CON & Moratorium
Day Care Agencies	Moratorium Only

ARKANSAS

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a patient-specific[1] rate. The method employed level of care as a peer group. The basic reimbursement method was adopted in 1981. Annual rates were set using a state fiscal year beginning July 1. 1990 Cost reports were used for 1993. Inflation based on the CPI plus other state factors were used to trend rates. The minimum occupancy standard was set at 85%.

Adjustments

Not adjusted.

Cost Centers

Arkansas separated reimbursement into four cost centers: Room and Board; Health Care; Maintenance and Operating; and General Administration. No limits were applied.

Ancillary Services

Physical Therapy, Occupational Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation and oxygen were included in the rate.

Case-Mix Adjusters

Case-mix adjusters were used in Arkansas. They had four levels of care. Patients were measured by an acuity measurement. Rates were on an individual basis. The entire rate was case-mix adjusted.

Capital Costs

Arkansas determined the value if capital based on historic cost. Actual Interest Expense valued Capital interest expense. Construction or renovation costs exceeding $100,000 must have had prior approval to be allowed. Rental costs or lease expense was allowed. Depreciation was allowed. The longest depreciation period allowed was twenty years, based on straight line depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for Arkansas was $54.86.

Other Long-Term Care

Arkansas uses the same system for hospital-based as for free-standing nursing facilities. It employs a retrospective method to set ICF-MR rates, which average almost three-times higher for state ICF-MRs than for nursing facilities, and even higher in other ICF-MRs. Home health services are reimbursed using a fee schedule with a flat rate. RN visits are paid over twice as much ($38) as are home health aide visits ($18). Adult day care is reimbursed through a waiver, using a prospective class methodology.

[1] Arkansas considered their rate a Class/Flat rate, but because the rate was entirely Case-Mix adjusted based on the individual it was re-categorized.

ARKANSAS

Free-Standing Nursing Facilities

Method	Prospective Patient-Specific
Average Reimbursement Rate	$54.86
Percentage Rate Change From Previous Year	11.85%
Peer Groupings	Level of Care
Year of Cost Report to Set Rate	1990
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	Acuity Measurement Entire Rate Case-Mix Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy — Occupational Therapy Non-Prescription Drug — Medical Supplies Durable Med. Equip. — Patient Transport Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective
Average Reimbursement Rate	
State Facilities	$153.80
Private Facilities	$174.10
Capital Reimbursement Determination (all facilities)	Historic Cost
Ancillary Services Included in Rate	
State Facilities	Included All Ancillary Services
Private Facilities	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$38.00 (Medicaid maximum cap)
Average Reimbursement Rate, HH Aide Visit	$18.00

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Class
Program	2176 Waiver
Average Rate by Service	
Social	Not Calculated
Day Health	Not Calculated

Sub-Acute Care

No Separate Program

CALIFORNIA

Nursing Homes

The number of nursing homes in California fluctuated between 1978 and 1992, with a low of 1,208 in 1984 and a high of 1,397 in 1993, the most nursing homes in the country. The number of nursing home beds fluctuated less so, reaching 128,411 in 1993 - the most nursing home beds in the country but a ratio of beds per 1000 population aged 65 and over less than the national average (38.9 compared to 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in California, including the large ICF/DDs and the smaller ICF/DD-Hs and ICF/DD-Ns, has been steadily increasing, from 386 facilities in 1989 to 590 in 1993. The number of beds increased from 10,036 to 10,889 during this period, the third highest number of ICF/MR beds in the country. The ratio of ICF/MR beds per 1000 population was .35 in 1993, substantially less than the national ratio of .53.

Other Residential Care

California has two categories of residential care (not including residential care for the chronically ill) - adult residential care for ages 18 to 59, and residential care for the elderly aged 60 and over. The total number of residential care facilities increased from 8,336 in 1989 to 8,864 in 1993. California had 145,846 residential care beds in 1993, the most residential care beds in the country.

Adult Day Care and Home Health Care

California had 555 adult day care facilities in 1993, the most in the country. Home care has been growing rapidly in California, increasing from 456 licensed agencies in 1989 to 1,089 in 1993, the third most in the country.

CON/Moratorium

California had a CON for nursing homes from 1978 to 1986, dropped it in 1987 and has had neither a CON nor a moratorium through 1993. In 1993 there was neither a CON nor a moratorium on hospital bed conversion, ICF/MRs, residential care, or home health care. There has not been a CON or moratorium for home health care for at least 15 years.

CALIFORNIA

Demographics

Percentage Population 65 and Over	11 % (US 12.7%)
Percentage Population 85 and Over	1.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	1397
Total Beds	128411
Beds Per Nursing Home	91.9
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	38.9 (US 53.0)
Age 85 and Over	379 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.36 (US 6.2)
Expenditures Per 1000 Pop, 1992	$58,161 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	590
Total Beds	10889
Beds Per Facility	18.5
Beds Per 1000 Population	0.35 (US 0.53)

Other Residential Care For Aged

Total Facilities	8864
Total Beds	145846
Beds Per Facility	16.5
Beds Per 1000 Pop, Age 65+	44.16 (US 19.6)

Adult Day Care For Aged

Total Facilities	555
Facilities Per 1000 Pop, Age 65+	0.17 (US 0.10)

Home Health Care Agencies

Total Agencies	1089
Agencies Per 1000 Pop, Age 65+	0.33 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.11 (US 3.6)
Expenditures Per 1000 Pop, 1992	$1,214 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	No CON nor Moratorium
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

CALIFORNIA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on Class rates. The method employed two peer groupings for level B (SNF) only: Geographic Location and Number of Beds (related to level of care). The basic reimbursement method was adopted in 1978. Rates were set based on a Medi-Cal period August to July. California rebased annually. The earliest possible cost report used was fiscal year ending July 1991. Inflation, based on the California CPI, labor index, with property allowed two percent, was used to trend rates. No minimum occupancy standard was used.

Adjustments

No adjustments to the initial rates were made upward or downward, during or after the rate period.

Cost Centers

Four cost centers were used in California: Capital; Property Tax; Salaries, Wages, and Benefits; and All Other. No limits were applied.

Ancillary Services

All Ancillaries were billed and reimbursed separately from the rate.

Case-Mix Adjusters

No case-mix adjusters were used in California. Two levels of care [facility types A (ICF) and B (SNF)] are available in California.

Capital Costs

Historic Cost was used to determine the value of Capital in California. For capital-interest expenses, nursing facilities used the Medicare System. Refinancing, and Renovation as well as Rental Costs and Leases were allowed as costs. Capital costs included depreciation, and interest, The American Hospital Guidelines were applied for depreciation. Straight line depreciation was used.

Reimbursement Rate

The average 1993 reimbursement rate for California was $76.28, calculated by average days of care. The Operating portion costs totaled $68.28 and the Capital portion cost was $7.63.

Other Long-Term Care

California pays for hospital-based nursing facility care at contracted rates, which average over twice the average rate for free-standing nursing facilities. ICF-MR is reimbursed using retrospective methods. Home health payment is prospective, cost-based. Adult day care is reimbursed using a prospective class method. Sub-acute care is paid using a prospective patient-specific method, at an average rate for ventilator care almost double that of hospital-based nursing facility care.

CALIFORNIA

Free-Standing Nursing Facilities

Method	Prospective Class
Average Reimbursement Rate	$76.28
Percentage Rate Change From Previous Year	5.5%
Peer Groupings	Geographic Location and Number of Beds
Year of Cost Report to Set Rate	1991
Inflation Adjustment	California CPI, Labor Index, Property
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	None

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$182.22

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	
State Facilities, Interim	$185.73
Private Facilities	$84.41
Capital Reimbursement Determination (all facilities)	Historic Cost
Ancillary Services (all facilities)	Non-Prescription Drug Medical Supplies Durable Med. Equip. Patient Transport Physician Services (general)

Home Health

Method	Prospective Cost-Based
Average Reimbursement Rate, RN Visit	$63.60 (1 hour visit)
Average Reimbursement Rate, HH Aide Visit	$38.87 (2 hour minimum visit)

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Class
Program	Waiver
Average Rate	$45.85
Facility types	Social, Day Health, Dementia/Alzheimers Disease
Clients Covered	Aged, Physically Disabled, Mentally Ill, AIDS/HIV, Pediatric

Sub-Acute Care

Method	Prospective Patient-Specific
Ventilator	$345.56

COLORADO

Nursing Homes

The number of nursing homes in Colorado has been growing slowly, from 184 in 1978 to 226 in 1993. The number of beds decreased from 20,066 in 1978 to 20,019 in 1993, making Colorado one of only two states to show a decrease in beds over this period.

Intermediate Care for Mentally Retarded

The number of ICF/MR beds has been steadily dropping in Colorado, from 1,187 in 1989 to 500 in 1993 - a ratio of beds per 1000 population of .14, compared to a U.S. average of .53. The number of ICF/MR facilities has been dropping as well, from 14 in 1991 to 7 in 1993.

Other Residential Care

Residential care in Colorado is provided in personal care homes. In 1993 there were 337 homes with 6,664 beds, an average of 19.8 beds per facility - about three beds above the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Colorado. Home care is not licensed but the number of certified home agencies has been slowly increasing, from 109 in 1989 to 143 in 1993.

CON/Moratorium

Colorado had a CON for nursing homes from 1978 to 1986, dropped it between 1987 and 1989, and in 1990 instituted a moratorium. In 1993 the moratorium covered hospital bed conversion but did not include ICF/MRs, residential care, or home health care. Colorado has not had a CON or moratorium for home health agencies for at least 14 years.

COLORADO

Demographics

Percentage Population 65 and Over	10 % (US 12.7%)
Percentage Population 85 and Over	1.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	226
Total Beds	20019
Beds Per Nursing Home	88.6
Average Occupancy Rate	91.6
Beds Per 1000 Population:	
Age 65 and Over	56 (US 53.0)
Age 85 and Over	521.3 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.16 (US 6.2)
Expenditures Per 1000 Pop, 1992	$59,587 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	7
Total Beds	500
Beds Per Facility	71.4
Beds Per 1000 Population	0.14 (US 0.53)

Other Residential Care For Aged

Total Facilities	337
Total Beds	6664
Beds Per Facility	19.8
Beds Per 1000 Pop, Age 65+	18.65 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.89 (US 3.6)
Expenditures Per 1000 Pop, 1992	$23,406 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	Moratorium Only
Hospitial Bed Conversion	Moratorium Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

COLORADO

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing home care in the state of Colorado. This method was based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1982. Fair rental allowance was added in 1985. A facility fiscal year was used to set rates. The year endings tended to cluster December 31 (50%) and June 30 (30%). Rates were set and rebased annually. The earliest cost report used was from 1992. Inflation based on the CPIU was used to trend rates. Occupancy was imputed to 85% for urban facilities (except Class 5V) or actual if higher than 85%. Fair Rental allowance is the greater of 90% imputed occupancy or actual for all facilities.

Adjustments

Adjusted. Rates were adjusted upward during the rate period twice, once by cost report information and once by ceiling changes. There was one retroactive upward adjustment. All facilities were included in the adjustments.

Cost Centers

Colorado separated reimbursement into three cost centers: 1. Administration and General, ceiling is actual cost limited to the 85th percentile of Medicaid patient; 2. Health Care and Raw Food, limited to the 90th percentile of Medicaid patient; and 3. Fair Rental allowance.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Physician Services were included in the rate. Ancillaries were entered on the cost report, then when audited the cost was compared to the ceiling before the rate was set.

Case-Mix Adjusters

No case-mix adjusters were used in Colorado. They provided four levels of care.

Capital Costs

Appraisal/Reappraisal and a Rental Value (Fair Rental Allowance) was used to determine the value of capital. Per bed appraisals were capped at $33,741.00. Nursing home capital-interest expenses were valued for working capital at actual interest expense, subject to a ceiling. Depreciation or interest connected to capital related asset is already reimbursed through the fair rental allowance rate. Depreciation was based on the straight line method. Payments were based on a gross versus a net fair rental system. The rental factor was 9.375%.

Reimbursement Rate

The 1993 average reimbursement rate for Colorado was $71.28, weighted by days of care.

Other Long-Term Care

Colorado uses the same system for hospital-based as for free-standing nursing facilities, but uses straight prospective facility-specific methods without adjustments for ICF-MR, with average rates about 50% higher than for nursing facilities. Home health agencies are reimbursed using a fee schedule with flat rates, paying almost twice as much ($58.08) for a RN visit as for a home health aide visit ($30.78). Other residential care is paid under waiver using a prospective class method; and adult day care is reimbursed under waiver using a prospective facility-specific approach.

COLORADO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$71.28
Percentage Rate Change From Previous Year	-1.75%
Peer Groupings	None
Year of Cost Report to Set Rate	1992
Inflation Adjustment	CPI-Urban
Minimum Occupancy in Rate-Setting	85% Urban (except class 5) 90% Fair Rental Allowance for All
Case-Mix Adjusters	None
Capital Reimbursement Determination	Combination
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Physician Services

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific
Private Facilities	Prospective Facility-Specific
Capital Reimbursement Determination	
State Facilities	Historic Cost
Private Facilities	Appraisal/Rental Value
Average Reimbursement Rate	
State Facilities	$239.97
Private Facilities	$101.56
Ancillary Services Included in Rate (all facilities)	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$58.08
Average Reimbursement Rate, HH Aide Visit	$30.78

Other Residential Care For Aged

Method	Prospective Class
Program	2176 Waiver
Average Rate by Client	$13.20/Day (max)

Adult Day Care

Method	Prospective Facility-Specific, Class
Reimbursement Program	2176 Waiver
Average Rate by Service Offered	
Social	$36.00/Day
Other	$36.00/Day

Sub-Acute Care

No Separate Program

CONNECTICUT

Nursing Homes

The number of nursing homes fluctuated between 1978 and 1993 with a total increase from 293 to 347 during that period. The number of beds has been steadily increasing, from 24,169 in 1978 to 31,308 in 1993 - a ratio of beds per 1000 population aged 65 and over of 67.8, greater than the national average of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MRs fluctuated between 1989 and 1993 but grew from 131 to 143 facilities. The number of beds decreased from 1,522 to 1,327 during this period.

Other Residential Care

Residential care for the elderly in Connecticut is provided in homes for the aged. The number of these facilities dropped slightly between 1989 and 1993, from 128 to 120. The number of beds dropped with the facility drop from 3,248 to 3,104. The average number of beds per facility in Connecticut in 1993 was 25.9, about 10 beds above the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Connecticut. The number of licensed home care agencies has grown slightly, from 101 in 1989 to 115 in 1993.

CON/Moratorium

Connecticut had a CON for nursing homes from 1978 through 1993, adding a moratorium to it in 1991. In 1993 the CON/moratorium also covered hospital bed conversion. ICF/MRs and residential care had CONs in 1993 while home health had neither a CON or moratorium. There were 21 CON applications for nursing homes in 1993, none of which were denied.

CONNECTICUT

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.6 % (US 1.4%)

Nursing Home Facilities

Total Facilities	347
Total Beds	31308
Beds Per Nursing Home	90.2
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	67.8 (US 53.0)
Age 85 and Over	595.3 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	10.19 (US 6.2)
Expenditures Per 1000 Pop, 1992	$208878 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	143
Total Beds	1327
Beds Per Facility	9.3
Beds Per 1000 Population	0.4 (US 0.53)

Other Residential Care For Aged

Total Facilities	120
Total Beds	3104
Beds Per Facility	25.9
Beds Per 1000 Pop, Age 65+	6.72 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	115
Agencies Per 1000 Pop, Age 65+	0.25 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.85 (US 3.6)
Expenditures Per 1000 Pop, 1992	$53,120 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	CON Only
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

CONNECTICUT

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed two peer groupings: Geographic Location and Licensure levels of ICF and SNF. The basic reimbursement method was adopted in 1990. A state fiscal year was used to set annual rates beginning July 1. Cost reports used were 1990. Inflation based on the DRI was used to trend rates. The minimum occupancy standard was set at 90%.

Adjustments

Not adjusted.

Cost Centers

Connecticut separates reimbursement into five cost centers: Administration and general, limited to 110% of the median; Capital revenue, with no limit; Direct, limited to 135% of the median; Indirect, limited to 120% of the median; and Fair Rental.

Ancillary Services

Physical Therapy (maintenance only), Respiratory Therapy, Non-Prescription Drugs, and Medical Supplies, Durable Medical Equipment were included in the Indirect cost center portion of the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Connecticut. Two levels of care were provided.

Capital Costs

The value of Capital was determined by a combination of historic cost and a fair rental system. The systems delineated between profit and non profit nursing facilities. For capital-interest expense, facilities used the actual interest expense. Renovation was allowed as an add-on. Rental Costs and Leases were limited to the lower of cost or historical cost. Non-profit facilities used the lower of interest and depreciation or the fair rental value. The rental factor was one half times the Medicare rate of return. The American Hospital Guidelines were applied to depreciation. Straight line was used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for Connecticut was $118.00, weighted by days of care. The Operating portion of the rate was $107.00, Ancillaries were $1.00, and Capital was $10.00.

Other Long-Term Care

Connecticut does not have hospital-based nursing facilities. It uses the same method for ICF-MR as for nursing facilities, but pays nearly three-times as much on average for ICF-MR.

Home health rates are set using Medicare principles with state alterations. A prospective facility- specific method is used to set rates for adult day care.

CONNECTICUT

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$118.00
Percentage Rate Change From Previous Year	1.22%
Peer Groupings	Geographic Location and Level of Care
Year of Cost Report to Set Rate	1990
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost/Fair Rental
Ancillary Services Included in Rate	

Respiratory Therapy
Medical Supplies
Physical Therapy
Non-Prescription Drug
Durable Med. Equip.

Hospital-Based Nursing Facilities

None

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$306.78 (median)
Ancillary Services Included in Rate	

Medical Supplies
Non-Prescription Drug
Patient Transport

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$74.24/Visit
Average Reimbursement Rate, HH Aide Visit	$4.81/Quarter Hr.

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Facility-Specific
Program	CT Home Care
Average Rate	$1469.00/Month

Sub-Acute Care

No Separate Program

DELAWARE

Nursing Homes

The number of nursing homes in Delaware has been growing steadily, from 27 in 1978 to 57 in 1993 (including "rest (residential) homes"). The number of beds has also been growing, from 2,762 in 1978 to 5,552 in 1993. There were 63.8 beds per 1000 population aged 65 and over in 1993, greater than the national average of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Delaware has declined, from 11 in 1989 to 9 in 1993. The number of beds has been slowly decreasing, from 460 in 1989 to 429 in 1993, but the state still has a high ratio of beds per 1000 population - .61 in 1993 compared to the U.S. average of .53.

Other Residential Care

Delaware had 131 "rest family homes" with 386 beds in 1993, the second fewest residential care beds in the country. Delaware had an average of 2.9 beds in these facilities, the smallest ratio of beds per facility in the country.

Adult Day Care and Home Health Care

Adult day care is not licensed in Delaware (legislation is pending but has not yet passed). There were 27 licensed home care agencies and 19 certified agencies in 1993.

CON/Moratorium

Delaware had a CON for nursing homes from 1979 through 1993. In 1993 the CON also covered hospital bed conversion. It did not include ICF/MRs, residential care, or home health care. There was 1 CON application for nursing homes submitted and accepted in 1993.

DELAWARE

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.2 % (US 1.4%)

Nursing Home Facilities

Total Facilities	57
Total Beds	5552
Beds Per Nursing Home	97.4
Average Occupancy Rate	84
Beds Per 1000 Population:	
Age 65 and Over	63.8 (US 53.0)
Age 85 and Over	680.2 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.78 (US 6.2)
Expenditures Per 1000 Pop, 1992	$81,953 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	9
Total Beds	429
Beds Per Facility	47.7
Beds Per 1000 Population	0.61 (US 0.53)

Other Residential Care For Aged

Total Facilities	131
Total Beds	386
Beds Per Facility	2.9
Beds Per 1000 Pop, Age 65+	4.43 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	27
Agencies Per 1000 Pop, Age 65+	0.31 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.78 (US 3.6)
Expenditures Per 1000 Pop, 1992	$11,997 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

DELAWARE

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a patient-specific rate. The method employed the peer grouping Geographic Location. The basic reimbursement method was adopted in 1988. A federal fiscal year was used to set annual rates. Rates were rebased in 1992. Cost report used was 1992 fiscal year. Inflation was based on the CPI and the MCPI. Occupancy was set at 90% for existing homes and 75% for new homes.

Adjustments

Not adjusted beyond initial rate setting.

Cost Centers

Delaware separated reimbursement into six cost centers: 1. Administration, limited at 105% of the median; 2. Primary, limited per group mean; 3. Secondary. limited at 115% of the median; 4. Support, limited at 110% of the median; 5. Capital and 6. Ancillary (public[1]* only).

Ancillary Services

For private facilities, all ancillary services were billed and reimbursed separately from the rate. For public[1] facilities, all ancillary services were included in the rate.

Case-Mix Adjusters

Case-Mix Adjusters were used in Delaware. In April of 93 their system changed from five levels of care to eight levels of care based on an acuity measurement. Rates were set on an individual-patient basis. The rate was adjusted proportionally by certain cost centers. Service categories that were accounted for in the rate included Direct Nursing Care, Indirect Nursing Care, and Other patient care.

Capital Costs

The value of Capital was determined by Historic cost. Nursing facility capital-interest expenses were valued by Actual Interest Expense. Refinancing, Renovation, as well as Rental costs and Leases were allowed as costs. Depreciation charges were allowed. The American Hospital Guidelines were used for depreciation. Depreciation was based on Straight Line.

Reimbursement Rate

The 1993 averaged reimbursement rate for Delaware was $86.16, calculated by days of care.

Other Long-Term Care

Delaware uses the same system for hospital-based as for free-standing nursing facilities, but reimburses ICF-MR using a prospective facility-specific system, with an average rate about 50% higher than for nursing facilities. Home health agencies are reimbursed using Medicare principles, but with state alterations, with a cap for RN payment nearly four-times higher than for home health aide. Delaware Medicaid pays under waiver for other residential care for the aged, using either prospective patient- or facility-specific methods; and reimburses under waiver for adult day care, using prospective facility-specific methods.

[1] Ninety percent of Delaware's facilities were Private and ten percent were Public.

DELAWARE

Free-Standing Nursing Facilities

Method	Prospective Patient-Specific
Average Reimbursement Rate	$86.16
Percentage Rate Change From Previous Year	5.33%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1992
Inflation Adjustment	CPI & MCPI
Minimum Occupancy in Rate-Setting	90% (exisiting homes) & 75% (new homes)
Case-Mix Adjusted	Direct Nursing, Indirect Nursing, & Other Patient CM Measurement, Acuity Measure
Capital Reimbursement Determination	Historic Cost
Ancillary Services[1] Included in Rate (public only)	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Physician Services
Speech Therapy	Prescription Drug

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Facility-Specific with No Peer Groupings and No Cost Center Caps
Average Reimbursement Rate	$132.00
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$95.44 (cap)
Average Reimbursement Rate, HH Aide Visit	$27.54 (cap)

Other Residential Care For Aged

Method	Retrospective Patient/Facility-Specific
Program	2176 Waiver
Average Rate: Residential	$82.99
Clients Covered	Physically Disabled

Adult Day Care

Method	Prospective Facility-Specific
Programs	Waiver
Average Rate	Not Available

Sub-Acute Care

No Separate Program

[1] Ninety percent of Delaware's facilities were private and ten percent were public. All ancillary services were billed separately in private facilities.

DISTRICT OF COLUMBIA

Nursing Homes

The number of nursing homes in Washington, D.C. grew from 12 in 1978 to 17 in 1983 and then remained constant at 17 for 7 years. In 1993 there were 19 facilities. The District has the fewest nursing homes in the country, the second fewest beds (3,195 in 1993), and a ratio of beds per 1000 population aged 65 and over less than the national average (41.5 compared to 53.0).

Intermediate Care for Mentally Retarded

There were 116 ICF/MRs with a total of 762 ICF/MR beds in 1993, a growth of 3 facilities and 14 beds since 1992 and the second highest ratio of beds per 1000 population in the country (1.32 compared to the U.S. average of .53). There was an average of 6.6 ICF/MR beds per facility in Washington, D.C. in 1993, the third smallest ratio in the country.

Other Residential Care

The number of community residential facility beds in D.C. has been declining, from 2,913 in 1989 to 1,669 in 1993. The number of facilities has similarly been declining, from 363 in 1989 to 218 in 1993.

Adult Day Care and Home Health Care

Adult day care is not licensed in Washington, D.C. Home care is not licensed. Twenty-three home care agencies were certified in 1993.

CON/Moratorium

Washington, D.C. had a CON on nursing homes from 1978 to 1993, with a brief moratorium added to it from October 1988 to February 1989. In 1993 the CON covered hospital bed conversions, residential care, and home health care. It did not cover ICF/MRs. There were 4 CON applications for nursing homes in 1993, only 1 of which was denied.

DISTRICT OF COLUMBIA

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.7 % (US 1.4%)

Nursing Home Facilities

Total Facilities	19
Total Beds	3195
Beds Per Nursing Home	168.2
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	41.5 (US 53.0)
Age 85 and Over	321 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.57 (US 6.2)
Expenditures Per 1000 Pop, 1992	$216104 (US $92,314)
Adequacy of Bed Supply	Under Supply

Intermediate Care For Mentally Retarded

Total Facilities	116
Total Beds	762
Beds Per Facility	6.6
Beds Per 1000 Population	1.32 (US 0.53)

Other Residential Care For Aged

Total Facilities	218
Total Beds	1669
Beds Per Facility	7.7
Beds Per 1000 Pop, Age 65+	21.69 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.79 (US 3.6)
Expenditures Per 1000 Pop, 1992	$22,468 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	CON Only
Home Health Care Agencies	CON Only
Day Care Agencies	CON Only

DISTRICT OF COLUMBIA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer grouping. The basic reimbursement method was adopted in 1985. A state fiscal year was used to set annual rates beginning October 1. The 1992 Cost reports were used for 1993. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 95%.

Adjustments

Limited Adjustments.

Cost Centers

The District of Columbia separates reimbursement into three cost centers: 1. Nursing and Patient Care, limited to 125% of the median; 2. Routine and Support, limited to 110% of the median; and 3. Capital.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, Physician Services, and Speech are included in the rate. Ancillaries are under the Patient Care portion of the rate.

Case-Mix Adjusters

No case-mix adjusters were used FY1993.

Capital Costs

The Market Value determined the value of capital. Capital-interest expenses were valued by the Medicare System. Refinancing, Renovation, and Rental costs and Leases were allowable costs. The Money Market rate was the cap on interest. Depreciation Charges were allowed. The Straight Line method was used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for DC was $162.05, weighted by facilities.
times as much for a RN visit ($65.00) as for an hour of home health aide services ($12.50).

Other Long-Term Care

The District of Columbia does not have hospital-based nursing facilities. It pays for home health using a fee schedule with a flat rate, paying five

times as much for a RN visit ($65.00) as for an hour of home health aide services ($12.50).

DISTRICT OF COLUMBIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$162.05
Rate Increase, 1991-1992	27%
Peer Groupings	None
Year of Cost Report to Set Rate	1992
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Market Value
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Physician Services
Speech Therapy	

Hospital-Based Nursing Facilities

None

ICF-MR

Not Available

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$65.00/Visit
Average Reimbursement Rate, HH Aide Visit	$12.50/Hour

Other Residential Care For Aged

None

Adult Day Care

Not Available

Sub-Acute Care

Not Available

FLORIDA

Nursing Homes

The number of nursing homes in Florida has been steadily increasing, from 333 in 1978 to 612 in 1993. The number of beds has similarly increased, from 34,939 in 1978 to 72,714 in 1993. Florida has the third lowest ratio of nursing home beds per 1000 population aged 65 and over in the country (28.6 compared to a U.S. average of 53.0).

Intermediate Care for Mentally Retarded

Florida had 73 ICF/MRs with a total of 3,215 beds in 1993, a ratio of 44 beds per facility - just about double the national average.

Other Residential Care

Florida licenses two categories of residential care - adult congregate living for the elderly, handicapped adults, and disabled adults, and adult foster care. The total number of facilities grew from 1,914 in 1989 to 2,322 in 1993 with a total growth in beds from 59,180 to 61,885, the second highest number of residential care beds in the country.

Adult Day Care and Home Health Care

Adult day care in Florida has grown from 97 facilities in 1989 to 116 in 1993. There were 1,309 licensed home care agencies in 1993, the most in the country.

CON/Moratorium

Florida had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. In 1993 there were 128 CON applications submitted for nursing homes, the most applications in the country. Sixty-five of these applications were denied.

FLORIDA

Demographics

Percentage Population 65 and Over	19 % (US 12.7%)
Percentage Population 85 and Over	1.8 % (US 1.4%)

Nursing Home Facilities

Total Facilities	612
Total Beds	72714
Beds Per Nursing Home	118.8
Average Occupancy Rate	92.1
Beds Per 1000 Population:	
Age 65 and Over	28.6 (US 53.0)
Age 85 and Over	294.3 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.96 (US 6.2)
Expenditures Per 1000 Pop, 1992	$63,023 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	73[1]
Total Beds	3215[1]
Beds Per Facility	44
Beds Per 1000 Population	0.24 (US 0.53)

Other Residential Care For Aged

Total Facilities	2322
Total Beds	61885
Beds Per Facility	26.7
Beds Per 1000 Pop, Age 65+	24.37 (US 19.6)

Adult Day Care For Aged

Total Facilities	116
Facilities Per 1000 Pop, Age 65+	0.05 (US 0.10)

Home Health Care Agencies

Total Agencies	1309
Agencies Per 1000 Pop, Age 65+	0.52 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.14 (US 3.6)
Expenditures Per 1000 Pop, 1992	$5,166 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

FLORIDA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing home care in the state of Florida. This method was based on a class/flat rate. The method employed two peer groupings: Geographic Location, North and South Counties, and Number of beds (two groups). The two peer groupings were used to create four Classes with specific ceilings. The basic reimbursement method was adopted in 1983 with some amendments. A state fiscal year was used to set semi-annual rates in January and July. The earliest Cost report data used was 1989. Florida used a Target Rate System which controlled and limited the rate. The Target rate included costs for Operating and Patient Care. Inflation based on the DRI was used to trend rates. Occupancy (Low Occupancy Adjustment) was set by changes in Standard Deviations of the total state average.

Adjustments

Adjusted. The rate was adjusted twice during the FY93 rate period. The rate for approximately eighty percent of Florida's facilities were decreased once during the rate period by $1.50

Cost Centers

Florida separated reimbursement into four cost centers: 1. Operating Costs, limited by the Target Rate System and Class ceiling of state-wide mean plus one standard deviation; 2. Patient Care Cost, limited by the Target Rate System and a state wide mean plus two standard deviations; 3. Property; and 4. Return-on-equity.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Patient Transportation and Oxygen were included in the rate under the Patient Care component.

Case-Mix Adjusters

No case-mix adjusters were used in Florida. There were three levels of care.

Capital Costs

Two systems were used in Florida.
For those using the Historic system Refinancing, Renovation, and Rental costs and leases were allowed with a cap of $13.65. The American Hospital Guidelines were used with the straight line method for depreciation. Equity was provided on Cost based only. Depreciation and interest expense was an allowable cost.
The Fair Rental Value System began on October 1, 1985. FRVS based on Historical Acquisition Costs (determined from most current depreciation schedule) was indexed forward. The per-bed ceiling was $32753.00 for January 1993. The Fair Rental system allowed construction cost and indexing. The rental system was applied to an appreciating property base.

Reimbursement Rate

The 1993 average reimbursement rate for Florida was $80.48, weighted by number of facilities and months.

Other Long-Term Care

Florida uses the same system for hospital-based as for free-standing nursing facilities, and the same for ICF-MR, but at an average rate nearly three-times higher than for nursing facilities. Home health agencies are reimbursed using a fee schedule with a flat rate, paying about twice as much ($36.25) for a RN visit as for a home health aide visit ($18.87). Florida Medicaid pays under waiver for adult day care, using negotiated contract fees.

FLORIDA

Free-Standing Nursing Facilities

Method	Prospective Class, Adjusted
Average Reimbursement Rate	$80.48
Percentage Rate Change From Previous Year	4.9%
Peer Groupings	Number of Beds & Geographic Location
Year of Cost Report to Set Rate	1989
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	Low Occupancy Rate
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost or Fair Rental
Ancillary Services Included in Rate	

Physical Therapy	Respiratory Therapy
Occupational Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Oxygen

Hospital-Based Nursing Facilities

None

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$234.28
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$36.25
Average Reimbursement Rate, HH Aide Visit	$18.87

Other Residential Care For Aged

None

Adult Day Care

Method		Contract Negotiations
Program		2176/1915c Waivers
Average Rate		
By Facility:	Day Health Average Rate	$40.00/Hour
By Client:	Aged & Physically Disabled	$40.00/Hour
	AIDS / ARC	$30.00/Hour

Sub-Acute Care

No Separate Program

GEORGIA

Nursing Homes

The number of nursing home facilities in Georgia fluctuated between 1978 and 1993, reaching a low of 342 in 1988, increasing to 368 in 1992, and then decreasing again to 361 in 1993. The number of beds increased from 30,588 in 1978 to 39,923 in 1992 but decreased to 39,145 in 1993. The ratio of beds per 1000 population aged 65 and over was 56.3 in 1993, slightly greater than the national average.

Intermediate Care for Mentally Retarded

Georgia had 12 ICF/MR facilities and 2,240 ICF/MR beds in 1993. This is an average of 186.7 beds per facility, one of the highest bed per facility ratios in the country.

Other Residential Care

Georgia licenses three categories of residential care - family living (2-6 beds), group living (7-15 beds), and congregate living (16 beds and up). The totals of these facilities and beds have been steadily increasing - in 1989 there were 1,088 facilities with 7,940 beds; in 1993 there were 1,505 facilities with 12,868 beds. The average number of beds per facility in Georgia in 1993 was 8.6, about half the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Georgia. The number of licensed home care agencies has been gradually increasing, from 76 in 1990 to 89 in 1993.

CON/Moratorium

Georgia had a CON for nursing homes from 1979 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, residential care, and home health care. There were 32 CON applications for nursing homes submitted in 1993, 12 of which were denied.

GEORGIA

Demographics

Percentage Population 65 and Over	10 % (US 12.7%)
Percentage Population 85 and Over	1.0 % (US 1.4%)

Nursing Home Facilities

Total Facilities	361
Total Beds	39145
Beds Per Nursing Home	108.4
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	56.3 (US 53.0)
Age 85 and Over	558 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.53 (US 6.2)
Expenditures Per 1000 Pop, 1992	$73,304 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	12
Total Beds	2240
Beds Per Facility	186.7
Beds Per 1000 Population	0.32 (US 0.53)

Other Residential Care For Aged

Total Facilities	1505
Total Beds	12868
Beds Per Facility	8.6
Beds Per 1000 Pop, Age 65+	18.51 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	89
Agencies Per 1000 Pop, Age 65+	0.13 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.97 (US 3.6)
Expenditures Per 1000 Pop, 1992	$8,949 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	CON Only
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

GEORGIA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1978. A state fiscal year was used to set and rebase rates annually beginning July 1. The 1992 Cost report was used for 1993. Inflation based on the DRI was used to trend rates. A minimum occupancy standard was used for the property portion of the rate.

Adjustments

The rate was adjusted upward during the rate period by appeal for all facilities.

Cost Centers

Five cost centers were used for setting reimbursement rates in Georgia: 1. Routine and Special Services, limited to the 90th percentile; 2. Dietary, limited to the 85th percentile; 3. Laundry and Housekeeping and Operation and Maintenance of Plant, limited to the 85th percentile; 4. Administrative and General, limited to the 70th percentile; and 5. Property and Related, limited to the 90th percentile.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, Physician Services, Oxygen, Speech and, Recreational were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Georgia. Georgia incorporated four levels of care.

Capital Costs

The value of capital was determined by a combination of Historic Cost, Replacement Cost, Market Value, and a Rental Value. Actual Interest Expense or 11% (dependent on Property transaction) valued capital-interest expenses. Refinancing (interest and depreciation), and Rental Costs and Leases were allowed as costs. Depreciation charges were allowed. Depreciation was based on Straight Line. The American Hospital Guidelines were used for depreciation. A return on net equity was allowed for all facilities limited to 11%. The rental factor was applied to an appreciating property base. This factor was based on a real rate of return.

Reimbursement Rate

The 1993 average reimbursement rate for Georgia was $67.02 averaged by the number of facilities between free-standing and hospital based.

Other Long-Term Care

Georgia uses the same system for hospital-based as for free-standing nursing facilities, averaging a per diem rate about 25% higher. It uses the same method for ICF-MR rates, which average almost three-times higher than for free-standing nursing facilities. Home health rates are set using a prospective agency-specific system that pays the same average rate ($52.26) for a RN visit as for a home health aide visit. Adult day care is paid under waivers, using a retrospective flat rate.

GEORGIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$67.02
Percentage Rate Change From Previous Year	5.56%
Peer Groupings	None
Year of Cost Report to Set Rate	1992
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	NA
Case-Mix Adjusters	None
Capital Reimbursement Determination	Combination
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Physician Services
Oxygen	Recreational & Speech

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$82.04

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$183.45
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Prospective Agency Specific
Average Reimbursement Rate, RN Visit	$52.26
Average Reimbursement Rate, HH Aide Visit	$52.26

Other Residential Care For Aged

Method	Retrospective Flat Rate
Programs	2176, 1915c, & 1915d Waivers
Average Rate by Facility	
Group Home	$18.38/Day
Family Home	$8.09/Day
Residential Care	$125.15/Day
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Adult Day Care

None

Sub-Acute Care

No Separate Program

HAWAII

Nursing Homes

The number of nursing homes in Hawaii remained constant between 1978 and 1986 (increasing from 32 to 33) but has been slowly growing since then, with a total of 43 in 1993. The number of beds has been steadily increasing, from 2,381 in 1978 to 3,497 in 1993. The ratio of beds per 1000 population aged 65 and over was 25.6 in 1993, the second smallest ratio in the country.

Intermediate Care for Mentally Retarded

Hawaii had 13 ICF/MR facilities and 208 ICF/MR beds in 1993, as it did in 1992. The ratio of beds per 1000 population in 1993 was .18, substantially less than the national averge of .53.

Other Residential Care

Hawaii licenses its residential care by size - type 1 facilities have 4-5 beds, type 2 facilities 6 or more beds. There were 501 residential facilities with 2,580 beds in Hawaii in 1993, a drop of 2 facilities and 52 beds since 1992. There was an average of 5.1 beds per facility in 1993, the second smallest average in the country.

Adult Day Care and Home Health Care

Adult day care has been decreasing in Hawaii, dropping from 20 facilities in 1989 to 19 in 1992 to 14 in 1993. There were 33 licensed home care agencies, all certified, in 1993.

CON/Moratorium

Hawaii had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. In 1993 there was 1 CON application submitted and accepted for nursing homes.

HAWAII

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.0 % (US 1.4%)

Nursing Home Facilities

Total Facilities	43
Total Beds	3497
Beds Per Nursing Home	81.3
Average Occupancy Rate	95.1
Beds Per 1000 Population:	
Age 65 and Over	25.6 (US 53.0)
Age 85 and Over	288.9 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.41 (US 6.2)
Expenditures Per 1000 Pop, 1992	$81,891 (US $92,314)
Adequacy of Bed Supply	Under Supply

Intermediate Care For Mentally Retarded

Total Facilities	13
Total Beds	208
Beds Per Facility	16
Beds Per 1000 Population	0.18 (US 0.53)

Other Residential Care For Aged

Total Facilities	501
Total Beds	2580
Beds Per Facility	5.1
Beds Per 1000 Pop, Age 65+	18.89 (US 19.6)

Adult Day Care For Aged

Total Facilities	14
Facilities Per 1000 Pop, Age 65+	0.1 (US 0.10)

Home Health Care Agencies

Total Agencies	33
Agencies Per 1000 Pop, Age 65+	0.24 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	0.55 (US 3.6)
Expenditures Per 1000 Pop, 1992	$1,042 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

HAWAII

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed peer groupings by facility type in two ways: Free-standing versus Hospital Band and ICF versus SNF. The basic reimbursement method was adopted in 1985. A state fiscal year was used to set annual rates beginning July 1. The last rebasing was in 1989. The 1985 Cost report was used for 1993. Inflation based on the DRI was used to trend rates. Facilities in Hawaii had a high occupancy (96.5%) making use of a minimum occupancy standard irrelevant.

Adjustments

Adjusted. Fifty percent of the facilities received an increase in rates during and retroactively to the rate period.

Cost Centers

Three cost centers were used for setting reimbursement rates in Hawaii: 1. Nursing, limited to 115% of state-wide average per peer group; 2. General & Administration, limited to 110% of state-wide average; and 3. Capital, limited to 110% of state-wide average.

Ancillary Services

Maintenance Therapy and Medical Supplies were included in the rate, as part of the Nursing component.

Case-Mix Adjusters

No case-mix adjusters were used in Hawaii. They had three levels of care.

Capital Costs

The value of capital was determined by historic cost. Capital-interest expenses were inflated forward from 1985, limited by a cap component. Refinancing, Renovations, and Rental Costs and Leases were allowed as costs. The Rental Costs and Leases cost was limited to the owner's cost. Depreciation was based on Straight Line. The American Hospital Guidelines were used for depreciation A return on net equity was provided using the Medicare formula to profit facilities only, based on 1985 figures.

Reimbursement Rate

The 1993 average reimbursement rate for Hawaii was $105.76, weighted by number of facilities.

Other Long-Term Care

Connecticut does not have hospital-based nursing facilities. It uses the same method for ICF-MR as for nursing facilities, but pays nearly three-times as much on average for ICF-MR.

Home health rates are set using Medicare principles with state alterations. A prospective facility-specific method is used to set rates for adult day care.

HAWAII

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$105.76
Percentage Rate Change From Previous Year	5.19%
Peer Groupings	Free-Standing vs. Hospital, Levels of Care
Year of Cost Report to Set Rate	1985
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	Actual Occupancy is 96.5%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Maintenance Therapy Medical Supplies

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$154.10

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$152.30
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

Method	Retrospective Flat Rate
Programs	2176 Waiver
Average Rate: Foster Home & Residential	
Level I:	$718.90/Month
Level II:	$803.90/Month
Level III:	$905.90/Month
Clients Covered	Aged, Physically Disabled, Developmentally Disabled

Adult Day Care

Method	Retrospective Contract Negotiation
Program	2176 Waiver
Facilities	Social, Day Health, Dementia/Alzheimers Disease
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill, Substance Abusing, AIDS/HIV, and Pediatric
Average Rate (all services)	$50.00/Day

Sub-Acute Care

No Separate Program

IDAHO

Nursing Homes

Idaho's nursing homes remained fairly constant between 1978 and 1987, increasing from 60 to 66 facilities during that period. The number of facilities has grown since then, to a total of 78 in 1993. The number of beds fluctuated between 1978 and 1983 but since then has grown to a total of 5,916 in 1993. The 1993 ratio of beds per 1000 population aged 65 and over was just less than the national ratio (45.6 compared to 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has been slowly increasing in Idaho, growing from 38 in 1990 to 47 in 1993. The number of beds grew from 531 in 1990 to 587 in 1991 but then decreased to 549 in 1993. The ratio of beds per facility in Idaho was 11.7 in 1993, about half the national average.

Other Residential Care

Idaho has five categories of residential care, only one of which is targeted for the elderly population. In 1989 there were 82 of these geriatric facilities with 1,852 beds; in 1993 there were 88 with 2,146 beds.

Adult Day Care and Home Health Care

Adult day care is not licensed in Idaho. There were 56 licensed home care agencies, 52 of them certified, in 1993.

CON/Moratorium

Idaho had a CON for nursing homes between 1979 and 1982 but dropped it in 1983 and has had neither a CON nor moratorium through 1993. In 1993 there was neither a CON nor moratorium for hospital bed conversion, ICF/MRs, residential care, or home health care. Idaho has not had a CON for home health care for at least 14 years.

IDAHO

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.2 % (US 1.4%)

Nursing Home Facilities

Total Facilities	78
Total Beds	5916
Beds Per Nursing Home	75.8
Average Occupancy Rate	88.5
Beds Per 1000 Population:	
Age 65 and Over	45.6 (US 53.0)
Age 85 and Over	438.9 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.68 (US 6.2)
Expenditures Per 1000 Pop, 1992	$58,261 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	47
Total Beds	549
Beds Per Facility	11.7
Beds Per 1000 Population	0.5 (US 0.53)

Other Residential Care For Aged

Total Facilities	88
Total Beds	2146
Beds Per Facility	24.4
Beds Per 1000 Pop, Age 65+	16.53 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	56
Agencies Per 1000 Pop, Age 65+	0.43 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.6 (US 3.6)
Expenditures Per 1000 Pop, 1992	$13,167 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	No CON nor Moratorium
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

IDAHO

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer grouping. Hospital Based facilities were separated for determining the prospective percentile caps. The basic reimbursement method was adopted in 1982. Facility year cost reports were used to set annual rates at the beginning of each facility fiscal year. The 1991 Cost reports were used for 1993. Inflation of costs were based on DRI indexes, the higher of Marshall Swift Construction, or CPI renters cost (to inflate the property rental component). The minimum occupancy standard was 80%.

Adjustments

Adjusted. Rates were set six times during a rate period.

Cost Centers

Two cost centers were used for setting reimbursement rates: 1. Plant and Operation including Property, Tax Insurance, Incentive, Exempt Cost, and Utilities (non-capped/retrospective adjustment). 2. Capped Costs including Dietary, Housekeeping, Laundry, Administration, Therapy Services, Maintenance, Supplies, Nursing Services, Employee Benefits, Social, Activities, and Nursing capped at the 75th percentile.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Idaho. One level of care was provided.

Capital Costs

The value of capital was determined by a Rental Value based on a property rental formula. The Rental Factor was 9.24. The rental rate ranges from $3.52 to $12.41 depending on facility age, type facility, and major capital improvements.

Reimbursement Rate

The 1993 average reimbursement rate for Idaho was $74.67, weighted by number of facilities. Operating Costs were estimated at $65.71, Ancillary Services were $1.49 and Capital Costs were $7.47.

Other Long-Term Care

Idaho uses a similar system for hospital-based as for free-standing nursing facilities, but with different rates, paying about a third-higher per diem rates on average. ICF-MR is reimbursed on the same basis as nursing facilities, but at a rate over twice as high. Home health agencies are reimbursed using Medicare principles, but with state alterations, with a cap for RN payment over twice that for home health aide visits. Sub-acute care is paid using either prospective facility-specific or patient-specific methods, with an average rate of $145.

[1] Idaho had a retrospective system with prospective caps ands interim rates, adjusted to cost at audit settlement. Retrospective systems with interim rates were re-categorized as Prospective.

IDAHO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$74.67
Percentage Rate Change From Previous Year	14.05%
Peer Groupings	None[1]
Year of Cost Report to Set Rate	1991
Inflation Adjustment	DRI & Higher of MSC[2] or CPI-Renters Cost
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Rental Value
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Oxygen

Hospital-Based Nursing Facilities

Method	Similar[3] to Free-Standing Nursing Facilities
Average Reimbursement Rate	$100.00

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$167.10
Capital Reimbursement Determination	Rental Value
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Medical Supplies	Durable Med. Equip.
Patient Transport	Oxygen
Non-Prescription Drug	

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$78.46 (cap)
Average Reimbursement Rate, HH Aide Visit	$34.98 (cap)

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

Method	Prospective Patient/Facility-Specific
Average Rate	$145.00

[1] Hospital Based facilities were separated for determining the prospective percentile caps.
[2] Marshall Swift Construction
[3] Property based on audit. Caps differ.

ILLINOIS

Nursing Homes

The number of nursing homes in Illinois dropped from 768 in 1979 to 730 in 1984, increased to 853 in 1992, and then dropped again to 846 in 1993. The number of beds fluctuated during that time but overall has increased, from 91,753 in 1985 to 103,501 in 1993 - the fourth highest number of beds in the country and a ratio of beds per 1000 population aged 65 and over of 70.0 (compared to the U.S. average of 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has been steadily increasing in Illinois, growing from 193 in 1990 to 236 in 1993. The number of beds has increased at the same time, from 6,520 in 1990 to 7,309 in 1993, a ratio of beds per population again higher than the national average (.62 compared to .53).

Other Residential Care

Illinois had 135 residential care facilities providing sheltered care in 1993, a drop of 17 since 1992. There were 7,640 beds in these facilities in 1993, a bed per facility ratio of 56.6 - the second highest ratio in the country.

Adult Day Care and Home Health Care

Adult day care is not licensed in Illinois. There were 403 licensed home care agencies, 291 of them certified, in 1993.

CON/Moratorium

Illinois had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion and ICF/MRs. It did not cover residential care or home health care. There were 37 CON applications for nursing homes in 1993, none of which were denied.

ILLINOIS

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	846
Total Beds	103501
Beds Per Nursing Home	122.3
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	70 (US 53.0)
Age 85 and Over	622 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.76 (US 6.2)
Expenditures Per 1000 Pop, 1992	$94,644 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	236
Total Beds	7309
Beds Per Facility	31
Beds Per 1000 Population	0.62 (US 0.53)

Other Residential Care For Aged

Total Facilities	135
Total Beds	7640
Beds Per Facility	56.6
Beds Per 1000 Pop, Age 65+	5.17 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	403
Agencies Per 1000 Pop, Age 65+	0.27 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.74 (US 3.6)
Expenditures Per 1000 Pop, 1992	$9,702 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

ILLINOIS

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of Geographic Location by region. The basic reimbursement method was adopted in early the 1980's. A state fiscal year was used to set and re-base annual rates beginning July 1. On July 1 rates were updated and set. In addition, each facility's resident case-mix was assessed in the rate year and rates were updated according to changes in the case-mix. The 1991 Cost report was used for 1993 rates. Inflation rates based on the DRI were used to trend rates. Rates were computed on the basis of a minimum occupancy standard.

Adjustments

No adjustments were made to the initial prospective rates to accommodate actual cost experience of the facilities.

Cost Centers

Three cost centers were used for setting reimbursement rates in 1993: 1. Administration and General Services, limited to the 75th percentile; 2. Capital, limited by uniform building cost; 3. Direct Car and Nursing, limited by average geographic wage and staff times for each of the specific services covered.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs[1], Medical Supplies, Durable Medical Equipment, and Oxygen were included in the direct nursing and care component of the rate.

Case-Mix Adjusters

Case-mix was adopted in the early 1980's. A patient acuity or needs service level measure was used in the case-mix system and direct care rates based on the particular facility's resident case-mix (the average per patient need-service level).

Capital Costs

Reimbursement for capital cost was based on a Fair Rental Value system. The rates were determined on the basis of the facility's specific building costs combined with uniform building costs, equipment costs and other capital costs. Renovations and improvements were allowable costs. A Return on Investment of eleven percent was made.

Reimbursement Rate

The 1993 average per patient reimbursement rate for Illinois was $70.08, weighted by number of Patients. Operating totaled $59.00, with ancillary services accounting for approximately $3.00 of the rate, Capital was $8.08.

Other Long-Term Care

Illinois uses the same method for hospital-based as for free-standing nursing facilities, and a similar method for ICF-MR. Home health is paid using Medicare principles, with the same average rate for RN as for home health aide.

visits ($41.50). Adult day care is paid under waiver, using a retrospective method. Sub-acute care is paid under a prospective patient-specific system.

[1] This includes general use stock drugs only.

ILLINOIS

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$70.08
Percentage Rate Change From Previous Year	12.61%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1991
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	Yes
Case-Mix Adjusters	Acuity Measure, Direct Nursing is CM Adjusted
Capital Reimbursement Determination	Fair Rental Value System
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Non-Prescription Drug, Oxygen, Durable Med. Equip.

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Similar to Free-Standing Nursing Facilities
Average Reimbursement Rate	$88.54[1]
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities, plus Patient Transport

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$41.50
Average Reimbursement Rate, HH Aide Visit	$41.50

Other Residential Care For Aged

None

Adult Day Care

Method	Retrospective Flat Rate
Program	2176 Wavier
Facilities	Social, Day Health, Dementia/Alzheimers Disease
Flat Rate	$27.53/Hour (unit cost)
Clients Covered	Aged, Physically Disabled, Mentally Ill, AIDS/HIV (all clients must be over 65)

Sub-Acute Care

Method by program/client	Prospective Patient-Specific
Average Rates (per diem)	
AIDS/ARC (level 1):	$110.00
AIDS/ARC (level 2):	$175.00
Ventilator	$241.00
Complex Respirator	$148.00
Head Trauma/Spinal Rehabilitation	$174.00

[1] The percentage rate change based on 1992 figure of $82.79.

INDIANA

Nursing Homes

The number of nursing homes in Indiana has been steadily increasing, from 492 in 1978 to 589 in 1993. The number of beds has fluctuated but has shown an overall increase, from 41,578 in 1978 to 59,683 in 1993. The ratio of beds per 1000 population aged 65 and over was 82.0 in 1993, the third highest ratio in the country.

Intermediate Care for Mentally Retarded

Indiana had 14 ICF/MR facilities with 1,151 beds in 1993. The average number of beds per facility was 82.2 in 1993, almost 4 times greater than the national average.

Other Residential Care

Indiana had 78 residential care facilities with 9,589 beds in 1993. The bed per facility ratio in 1993 was 122.9, the highest ratio in the country.

Adult Day Care and Home Health Care

Adult day care is not licensed in Indiana. The number of licensed home care agencies increased from 137 in 1989 to 265 in 1993, 167 of which were certified.

CON/Moratorium

Indiana had a CON for nursing homes from 1978 through 1993. In 1993 the CON also included ICF/MRs. It did not include hospital bed conversion, residential care, or home health care. There were 16 CON applications for nursing homes in Indiana in 1993, none of which were denied.

INDIANA

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	589
Total Beds	59683
Beds Per Nursing Home	101.3
Average Occupancy Rate	82.2
Beds Per 1000 Population:	
Age 65 and Over	82 (US 53.0)
Age 85 and Over	758.2 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.59 (US 6.2)
Expenditures Per 1000 Pop, 1992	$106668 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	14
Total Beds	1151
Beds Per Facility	82.2
Beds Per 1000 Population	0.2 (US 0.53)

Other Residential Care For Aged

Total Facilities	78[1]
Total Beds	9589[1]
Beds Per Facility	122.9
Beds Per 1000 Pop, Age 65+	13.17 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	265
Agencies Per 1000 Pop, Age 65+	0.36 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	0.9 (US 3.6)
Expenditures Per 1000 Pop, 1992	$6,416 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

INDIANA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping for Geographic location by region. The basic reimbursement method was adopted in 1983. A facility fiscal year was used to set and rebase rates annually. The 1992 Cost reports were used for 1993. Inflation based on the GNPIPD was used to trend rates. The minimum occupancy standard was set at 80%.

Adjustments

No adjustment was made to the initial reimbursement rate.

Cost Centers

Indiana separated reimbursement into eight cost centers: 1. Nursing; 2. Dietary; 3. Housekeeping and Laundry; 4. Plant Operations; 5. Ownership; 6. General and Administration; 7. Total employee benefits; and 8. Social Services. All cost centers were limited to the 90th percentile.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, and Durable Medical Equipment, were included in the rate under the appropriate cost center.

Case-Mix Adjusters

No case-mix adjusters were used to set rates in Indiana. Two levels of care were provided.

Capital Costs

Historic Cost determined the value of capital for nursing facilities in Indiana. No depreciation or revaluation of property were considered for rate setting. Actual interest expense valued interest expenses. A Return-on-equity based on net equity was provided.

Reimbursement Rate

The 1993 average reimbursement rate for Indiana was $66.56, calculated by number of days.

Other Long-Term Care

Indiana uses the same system for hospital-based as for free-standing nursing facilities, and a similar method for ICF-MR, with an average rate for private ICF-MRs nearly twice as high as for nursing facilities. State ICF-MR facilities are paid according to size, with large state ICF-MRs being paid twice the average rate as small state ICF-MRs. Home health agencies are reimbursed using a fee schedule with a flat rate, paying about 50% more ($64.93) for a RN visit as for a home health aide visit ($41.01). Adult day care is paid using a retrospective flat rate. Sub-acute care is reimbursed using a prospective facility-specific method.

INDIANA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$66.56
Percentage Rate Change From Previous Year	3.96%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1992
Inflation Adjustment	GNP-IPD
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Durable Med. Equip.

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Rate	
State Facilities	Small: $111.78 Large: $218.27
Private Facilities	$118.47
Ancillary Services (all facilities)	Excludes Prescription Drug & Physician Services
Capital Reimbursement Determination (all facilities)	Historic Cost

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$64.93
Average Reimbursement Rate, HH Aide Visit	$41.01

Other Residential Care For Aged

None

Adult Day Care

Method	Retrospective Flat Rate
Program	Yes
Average Rate	$5.50/Hour
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care

Method	Prospective Facility-Specific
Average Rate	
AIDS/HIV	$185.01 to $244.55
Ventilator Care	$150.53

IOWA

Nursing Homes

The number of nursing homes in Iowa increased steadily from 408 in 1978 to 450 in 1984, remained fairly constant between 1984 and 1988, and increased again to 479 in 1993. The number of beds has fluctuated but has grown from 30,369 in 1978 to 35,708 in 1993. The ratio of beds per 1000 population aged 65 and over was 81.9 in 1993, one of the highest ratios in the country.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities grew from 46 in 1990 to 81 in 1993. The number of beds increased during this time from 2,588 to 2,828. The ratio of ICF/MR beds per 1000 population was 1.0 in 1993, almost twice the national ratio of .53.

Other Residential Care

The number of residential care facilities in Iowa has been slowly decreasing, from 202 in 1989 to 183 in 1993. The number of beds dropped during this period from 7,667 to 6,844. The average number of beds per facility in Iowa was 37.4 in 1993, over twice the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Iowa. Home care is not licensed but in 1993 166 home care agencies were certified.

CON/Moratorium

Iowa had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, while a CON/moratorium covered ICF/MRs. There was neither a CON nor moratorium for residential care or home health care. In 1993 there were 12 CON applications submitted for nursing homes, only 1 of which was denied.

IOWA

Demographics

Percentage Population 65 and Over	16 % (US 12.7%)
Percentage Population 85 and Over	2.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	479
Total Beds	35708
Beds Per Nursing Home	74.5
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	81.9 (US 53.0)
Age 85 and Over	612.5 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.78 (US 6.2)
Expenditures Per 1000 Pop, 1992	$74,099 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	81
Total Beds	2828
Beds Per Facility	34.9
Beds Per 1000 Population	1 (US 0.53)

Other Residential Care For Aged

Total Facilities	183
Total Beds	6844
Beds Per Facility	37.4
Beds Per 1000 Pop, Age 65+	15.7 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.64 (US 3.6)
Expenditures Per 1000 Pop, 1992	$8,891 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

IOWA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1975. A facility fiscal year was used to set rates semi-annually and a maximum rate cap annually. Facilities clustered with the state fiscal year that began in July or the calendar year. Rebasing for 1993 was done in 1992. The 1992 Cost report or previous six months was used for 1993. Inflation based on CPI and an incentive were used to trend rates. Occupancy was set at minimum of 80%.

Adjustments

Adjusted. Iowa set rates on a six month period. Initial rates were adjusted downward twelve times during the FY93 period for two percent of facilities based on cost report and appeal.

Cost Centers

Cost centers were not used for setting reimbursement rates in Iowa.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation and oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Iowa. Two levels of care were provided.

Capital Costs

The value of capital was determined by Historic cost. Appraisals were used to establish expense for rent/lease arrangement or when the historic value was unknown. Actual Interest Expense valued capital-interest expenses. Refinancing, Renovation, and Rental Costs and Leases were allowed as costs. The Rental Costs and Leases cost was limited to the owner's cost. Depreciation charges were allowed. Straight Line was used for depreciation. Depreciation was based on a useful life of fourty years.

Reimbursement Rate

The FY1993 average reimbursement rate for Iowa was $56.27. Operating cost totaled $49.52, Ancillaries $ 1.13, and Capital $5.62.

Other Long-Term Care

Iowa uses the same system for hospital-based as for free-standing nursing facilities, averaging a slightly higher per diem rate. It uses the same method to set ICF-MR rates, which average over three times higher than rates for free-standing nursing facilities. Home health services are reimbursed under Medicare principles. Adult day care is covered under waivers, using a prospective facility-specific method.

IOWA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$56.27
Percentage Rate Change From Previous Year	5.96%
Peer Groupings	None
Year of Cost Report to Set Rate	1992 or Previous Six Months
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Combination
Ancillary Services Included in Rate	

Non-Prescription Drug	Durable Med. Equip.
Medical Supplies	Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$63.34

ICF-MR

Method	Same as Free-Standing Nursing Facilities, No Maximum Rate Amount
Average Reimbursement Rate	$180.00
Capital Reimbursement Determination	Historic Cost, Market Value, Rental Value
Ancillary Services Included in Rate	

Non-Prescription Drug	Durable Med. Equip.
Medical Supplies	Patient Transport
Physical Therapy	Occupational Therapy
Respiratory Therapy	Oxygen

Home Health

Method	Medicaid Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Facility-Specific
Program	1915c Waivers: Chronically Ill and Handicapped, Elderly, AIDS/HIV
Type of Service	Day Health
Average Rate: Aged	$30.95/Day

Sub-Acute Care

No Separate Program

KANSAS

Nursing Homes

The number of nursing homes in Kansas remained fairly constant between 1978 and 1985, then increased from 385 facilities in 1985 to 444 facilities in 1993. The number of beds reached 30,622 in 1992 but dropped to 29,783 in 1993. The ratio of beds per 1000 population aged 65 and over was 84.4 in 1993, the second highest ratio in the country.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities grew from 38 in 1989 to 48 in 1991 before declining to 46 in 1992 and 45 in 1993. The number of ICF/MR beds has remained fairly constant, increasing from 935 in 1989 to 976 in 1992 before dropping to 961 in 1993. The ratio of beds per facility in 1993 was 21.4, just about equalling the national average.

Other Residential Care

Kansas has five categories of residential care - intermediate personal care homes, personal care homes, boarding care homes, adult family homes, and residential facilities. There was a total of 225 facilities with 2,701 beds in 1993.

Adult Day Care and Home Health Care

Adult day care is not licensed in Kansas. There were 243 licensed home care agencies, 143 of them certified, in 1993.

CON/Moratorium

Kansas had a CON for nursing homes between 1978 and 1984 but dropped it in 1985 and has had neither a CON nor moratorium through 1993. In 1993 there was neither a CON nor moratorium on hospital bed conversion, ICF/MRs, residential care, or home health care. There has not been a CON or moratorium for home health care for at least 15 years.

KANSAS

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.9 % (US 1.4%)

Nursing Home Facilities

Total Facilities	444
Total Beds	29783
Beds Per Nursing Home	67.1
Average Occupancy Rate	89.16
Beds Per 1000 Population:	
Age 65 and Over	84.4 (US 53.0)
Age 85 and Over	636 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.99 (US 6.2)
Expenditures Per 1000 Pop, 1992	$75,090 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	45
Total Beds	961
Beds Per Facility	21.4
Beds Per 1000 Population	0.38 (US 0.53)

Other Residential Care For Aged

Total Facilities	225
Total Beds	2701
Beds Per Facility	12
Beds Per 1000 Pop, Age 65+	7.65 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	243
Agencies Per 1000 Pop, Age 65+	0.69 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.1 (US 3.6)
Expenditures Per 1000 Pop, 1992	$8,913 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	No CON nor Moratorium
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

KANSAS

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in the mid 70s. The calendar year 1992 cost reports were used to set rates. The rate was set on the following July 1st and was rebased yearly. Inflation based on the CPI (Historic) and the DRI (prospective) was used to trend rates. The minimum standard for occupancy was set at 85%.

Adjustments

Rate were adjusted for the 24 hour nursing factor, property fee re-basings and field audits.

Cost Centers

Four cost centers are used for reimbursement in Kansas. 1. Room and Board (laundry, housekeeping, and dietary) limited to the 90th percentile; 2. Administration limited at the 75th percentile; 3. Property limited at the 85th percentile; 4. Health Care limited at the 90th percentile.

Ancillary Services

Ancillary Services are included in the Health Care cost center. Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Patient Transportation, were included in the rate.

Case-Mix Adjusters

Kansas had no Case-Mix adjusters in 1993. A Case-mix demonstration was in place, moving to a Case-Mix system in FY1994. One level of care was provided.

Capital Costs

The value of capital was based on an imputed value. Kansas had a facility specific Property Fee, implemented in 1985. The fee was based on 1984 ownership costs (depreciation, mortgage interest, lease and amortization of lease expense). When the property fee was higher than ownership costs, the difference could have been considered a Return on Equity. The purpose of the property fee was to encourage the retention of ownership in nursing facilities.

Reimbursement Rate

The 1993 average reimbursement rate for Kansas was $51.24 based on days of care Operating costs including Ancillaries totaled $46.63; Capital was $4.50 per day.

Other Long-Term Care

Kansas uses the same system for hospital-based as for free-standing nursing facilities, and the same method for ICF-MR, with an average rate for ICF-MRs two-and-a-half times as high as for nursing facilities. Home health is reimbursed using a fee schedule with flat rates, 50% higher for RN visits ($60) as for home health aide visits ($40). Other residential care for the aged is covered under waiver, as is adult day care, using a prospective facility-specific method.

KANSAS

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$51.24
Percentage Rate Change From Previous Year	1.36%
Peer Groupings	None
Year of Cost Report to Set Rate	1992 (calendar year)
Inflation Adjustment	CPI (historic), DRI (prospective)
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	Case-Mix Demonstration
Capital Reimbursement Determination	Imputed Costs
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$135.41
Capital Reimbursement Determination	Actual Costs
Ancillary Services in Rate	Same as Free-Standing Nursing Facilities, Except Oxygen is Not Included.

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$60.00
Average Reimbursement Rate, HH Aide Visit	$40.00

Other Residential Care For Aged

Method	Prospective
Program	1915c Waiver
Average Rates	
Care	$6.58
Personal Care	$12.10
Care and Training	$23.00
Facility Types	Group, Family & Residential Homes
Clients Covered	Aged & Physically Disabled

Adult Day Care

Method	Prospective Facility-Specific
Program	1915c Waiver
Average Rate by Service	
Social	$20.00/Day
Day Health	$23.00/Day
Clients Covered	Aged & Physically Disabled

Sub-Acute Care

No Separate Program

KENTUCKY

Nursing Homes

The number of nursing homes in Kentucky dropped from 261 in 1978 to 227 in 1984 but since then has been increasing, reaching a total of 286 in 1993. The number of beds has fluctuated but has grown from 16,167 in 1978 to 24,586 in 1993. The ratio of beds per 1000 population aged 65 and over almost equalled the national ratio in 1993 (51.0 compared to 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities and beds has remained constant in Kentucky since 1990 - 9 facilities with 1,203 beds. The ratio of beds per facility was 133.7 in 1993, 6 times the national average.

Other Residential Care

Kentucky licenses two categories of residential care - personal care, in which there is no limit on the number of people housed, and family care, in which there is a limit of 3 on the number of people housed. There were 605 facilities in 1993 with a total of 8,563 beds, a bed per facility ratio of 14.2 - about two beds less than the national average.

Adult Day Care and Home Health Care

There were 27 licensed adult day care facilities in Kentucky in 1993, an increase of 2 since 1992. There were 117 licensed home care agencies, 103 of them certified, in 1993.

CON/Moratorium

Kentucky had a CON for nursing homes in 1978 and 1979, added a moratorium to it between 1980 and 1990, dropped the moratorium but kept the CON in 1991, and reinstated the moratorium (with the CON) through 1992 and 1993. In 1993 the CON/moratorium also covered ICF/MRs and home health care, while a CON alone covered hospital bed conversion. Residential care had neither a CON or moratorium. There were 4 CON applications for nursing homes in 1993, 2 of which were denied.

KENTUCKY

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	286
Total Beds	24586
Beds Per Nursing Home	86
Average Occupancy Rate	97.91
Beds Per 1000 Population:	
Age 65 and Over	51 (US 53.0)
Age 85 and Over	469.5 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.69 (US 6.2)
Expenditures Per 1000 Pop, 1992	$79,732 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	9
Total Beds	1203
Beds Per Facility	133.7
Beds Per 1000 Population	0.32 (US 0.53)

Other Residential Care For Aged

Total Facilities	605
Total Beds	8563
Beds Per Facility	14.2
Beds Per 1000 Pop, Age 65+	17.77 (US 19.6)

Adult Day Care For Aged

Total Facilities	27
Facilities Per 1000 Pop, Age 65+	0.06 (US 0.10)

Home Health Care Agencies

Total Agencies	117
Agencies Per 1000 Pop, Age 65+	0.24 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	10.46 (US 3.6)
Expenditures Per 1000 Pop, 1992	$22,519 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON & Moratorium
Day Care Agencies	CON & Moratorium

KENTUCKY

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of Geographic Location, Urban/Rural. The basic reimbursement method was adopted in 1977. In September of 1990 Kentucky added case-mix. A state fiscal year was used to set and rebased rates annually beginning July 1, with quarterly adjustments. The 1992 Cost report was used for 1993. Inflation based on the DRI and Case-mix were used to trend rates. The minimum occupancy standard was set at 90%.

Adjustments

Adjusted with quarterly adjustments.

Cost Centers

Two cost centers were used for setting reimbursement rates in Kentucky: 1. Nursing, limited to 115% of median by Urban/Rural; and 2. All Other

Ancillary Services

Medical Supplies, Durable Medical Equipment, and Patient Transportation, were included in the rate.

Case-Mix Adjusters

Case-mix was adopted October 1, 1990. Kentucky used Minnesota's Case-mix System, based on overall-facility set rates. The Direct Nursing Care was Case-mix adjusted.
Kentucky's Quality Assurance Team conducted paper reviews (200+ per year) for accuracy of resident data assessments.

Capital Costs

The value of capital was determined by historic cost. Actual Interest Expense valued capital-interest expenses. Refinancing (interest and depreciation), Renovation, and Rental Costs and Leases were allowable costs. The Rental Costs and Leases cost was limited to the cost of ownership. Straight Line was used for depreciation.

Reimbursement Rate

The 1993 reimbursement rate for Kentucky was we $64.03, calculated by days of care weighted by six month rate periods.

Other Long-Term Care

Kentucky uses the same system for hospital-based as for free-standing nursing facilities, and a similar methodology to set ICF-MR rates, which average over twice those for free-standing nursing facilities. Home health services are reimbursed using retrospective facility-specific methods, with an average payment for RN visits ($74.43) three times that for home health aides ($25.38).

KENTUCKY

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$64.03
Percentage Rate Change From Previous Year	7.6%
Peer Groupings	Geographic Location by Urban/Rural
Year of Cost Report to Set Rate	1992
Inflation Adjustment	DRI and Case-Mix
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	Used Minnesota CM System, Direct Nursing Portion was Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Medical Supplies Durable Med. Equip. Patient Transport

Hospital-Based Nursing Facilities

Method	Similar to Free-Standing Nursing Facilities

ICF-MR

Method	Similar to Free-Standing Nursing Facilities
Average Reimbursement Rate	$148.47

Home Health

Method	Retrospective Facility-Specific
Average Reimbursement Rate, RN Visit	$74.43
Average Reimbursement Rate, HH Aide Visit	$25.38

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

LOUISIANA

Nursing Homes

The number of nursing homes in Louisiana has fluctuated, growing from 235 facilities in 1978 to 343 in 1992 before dropping to 339 in 1993. The number of beds has been increasing steadily, from 22,541 in 1978 to 37,862 in 1993. The ratio of beds per 1000 population aged 65 and over was 77.7 in 1993, substantially higher than the U.S. ratio of 53.0.

Intermediate Care for Mentally Retarded

Louisiana licenses three different types of ICF/MRs - community homes, group homes, and residential facilities. In 1989 the total number of facilities was 327; by 1993 the total had increased to 441. The total number of beds, for all three types of facilities, increased from 6,396 in 1989 to 6,504 in 1992 before dropping to 6,498 in 1993. Louisiana had the highest ratio of beds per 1000 population in the country in 1993 - 1.51 compared to the U.S. average of .53.

Other Residential Care

There were 53 adult residential care facilities in Louisiana in 1993. The number of beds that year is estimated to be 371 (the state does not keep an exact number. Their smallest facility has 6 beds, their largest, 13 beds).

Adult Day Care and Home Health Care

Louisiana licenses four categories of adult day care - sheltered workshops, enclave models, psychosocial models, and mobile work crews. In 1993 there was a total of 169 adult day care facilities. There were 438 licensed home care agencies, all of them certified, in 1993.

CON/Moratorium

Louisiana has had a CON for nursing homes from 1978 through 1993. There was a moratorium on nursing homes in 1984 which was dropped in 1985. In 1993 Louisiana also had a CON on hospital bed conversion and ICF/MRs. There was neither a CON nor moratorium on residential care or home health care. There were 16 CON applications for nursing homes in 1993, only 1 of which was denied.

LOUISIANA

Demographics

Percentage Population 65 and Over	11 % (US 12.7%)
Percentage Population 85 and Over	1.3 % (US 1.4%)

Nursing Home Facilities

Total Facilities	339
Total Beds	37862
Beds Per Nursing Home	111.7
Average Occupancy Rate	87.8
Beds Per 1000 Population:	
Age 65 and Over	77.7 (US 53.0)
Age 85 and Over	662 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.52 (US 6.2)
Expenditures Per 1000 Pop, 1992	$96,044 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	441
Total Beds	6498
Beds Per Facility	14.7
Beds Per 1000 Population	1.51 (US 0.53)

Other Residential Care For Aged

Total Facilities	53
Total Beds	371[1]
Beds Per Facility	7
Beds Per 1000 Pop, Age 65+	0.76 (US 19.6)

Adult Day Care For Aged

Total Facilities	169
Facilities Per 1000 Pop, Age 65+	0.35 (US 0.10)

Home Health Care Agencies

Total Agencies	438
Agencies Per 1000 Pop, Age 65+	0.9 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.59 (US 3.6)
Expenditures Per 1000 Pop, 1992	$3,698 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

LOUISIANA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on Class rates. The method employed peer groupings by level of facility (IC1, IC2, and SN). The basic reimbursement method was adopted in 1982. A state fiscal year was used to set rates annually beginning July 1. No re-basing was performed in Louisiana. No Cost reports were used. Inflation based on the CPI (All Items, Food, Medical Care, and Wage) for December of preceding and second preceding year was used to trend rates. No minimum occupancy standard was used.

Adjustments

No adjustments to the initial rates were made.

Cost Centers

No cost centers were used to set rates.

Ancillary Services

Non-perspiration drugs, Medical Supplies, Durable Medical Equipment, and Oxygen were ancillary services included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Louisiana. Three levels of care facilities were provided: IC1, IC2, and SN.

Capital Costs

The value of capital was determined by historic cost. Rental Costs and Leases were allowable costs. Louisiana allowed for depreciation charges. Depreciation was based on straight line. The American Hospital Guidelines were used for depreciation periods. A Return-on-equity of five percent of the base flat rate was allowed for all nursing facilities.

Reimbursement Rate

The 1993 average reimbursement rate for Louisiana was $65.26, averaged by days.

Other Long-Term Care

Louisiana uses the same system for hospital-based as for free-standing nursing facilities. It employs a prospective patient-specific method for state and a prospective facility-specific method for private ICF-MRs, averaging nearly three-times the rate paid to nursing facilities. Home health agencies are paid using Medicare principles. Adult day care is covered under waiver.

LOUISIANA

Free-Standing Nursing Facilities

Method	Prospective Class	
Average Reimbursement Rate	$56.26	
Percentage Rate Change From Previous Year	2.25%	
Peer Groupings	Level of Care	
Year of Cost Report to Set Rate	Not Applicable	
Inflation Adjustment	CPI (all items)	
Minimum Occupancy in Rate-Setting	None	
Case-Mix Adjusters	None	
Capital Reimbursement Determination	Historic Cost	
Ancillary Services Included in Rate	Non-Prescription Drug	Oxygen
	Medical Supplies	Durable Med. Equip.

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method		
State Facilities	Prospective Patient-Specific	
Private Facilities	Prospective Facility-Specific	
Average Reimbursement Rate (all facilities)	$165.69[1]	
Capital Reimbursement Determination (all facilities)	Historic Cost	
Ancillary Services Included in Rate		
State Facilities	Pharmacy	Lab & X Ray
Private Facilities	None	

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	Waiver
Average Rate: Day Health	Limited to 80% of ICF 2 Level
Clients Covered	Aged

Sub-Acute Care

No Separate Program

[1] Overall average weighted by number of facility.

MAINE

Nursing Homes

The number of nursing homes in Maine has fluctuated but overall has shown a decrease from 162 facilities in 1978 to 145 in 1993. The number of beds has similarly fluctuated, growing from 8,693 in 1978 to 10,236 in 1992 before dropping to 10,129 in 1993. The ratio of beds per 1000 population aged 65 and over was 59.5 in 1993, somewhat greater than the national average.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has remained constant in Maine, increasing only from 45 to 46 between 1989 and 1993. The number of beds remained constant at about 740 between 1989 and 1991 but dropped to 706 in 1992 and to 622 in 1993, a ratio of beds per 1000 population just less than the national average.

Other Residential Care

There are two categories of residential care in Maine - boarding homes, with 5 or more beds, and foster care, with 4 or fewer beds. The total number of facilities declined from 530 in 1989 to 501 in 1993, with a slight increase in beds from 4,043 to 4,098. Maine had an average of 8.2 beds per facility in 1993, about half the national average.

Adult Day Care and Home Health Care

There were 13 licensed adult day care facilities in Maine in 1993, a drop of 1 since 1992. There were 56 licensed home care agencies in 1993, 24 of them certified.

CON/Moratorium

Maine had a CON for nursing homes from 1978 to 1980, added a moratorium to it between 1981 and 1989, dropped the moratorium (keeping the CON) in 1990, and then reinstated the moratorium with the CON in 1993. In 1993 the CON/moratorium also covered ICF/MRs, while a CON alone covered hospital bed conversion and home health care. In 1993 there was neither a CON nor moratorium on residential care. There were 6 CON applications for nursing homes in 1993, none of which were denied.

MAINE

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.7 % (US 1.4%)

Nursing Home Facilities

Total Facilities	145
Total Beds	10129
Beds Per Nursing Home	69.9
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	59.5 (US 53.0)
Age 85 and Over	490.4 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.29 (US 6.2)
Expenditures Per 1000 Pop, 1992	$163557 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	46
Total Beds	622
Beds Per Facility	13.5
Beds Per 1000 Population	0.5 (US 0.53)

Other Residential Care For Aged

Total Facilities	501
Total Beds	4098
Beds Per Facility	8.2
Beds Per 1000 Pop, Age 65+	24.09 (US 19.6)

Adult Day Care For Aged

Total Facilities	13
Facilities Per 1000 Pop, Age 65+	0.08 (US 0.10)

Home Health Care Agencies

Total Agencies	56
Agencies Per 1000 Pop, Age 65+	0.33 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.46 (US 3.6)
Expenditures Per 1000 Pop, 1992	$26,226 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

MAINE

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care. This method was based on a facility-specific rate. Free-standing facilities were separated from hospital based facilities. The basic reimbursement method was adopted in 1982. A facility fiscal year was used to set annual rates. Sixty percent of the facilities begin their rate year January 1. The 1993 rates were determined using the facility costs during the operating years beginning in 1990 inflated forward. Inflation based on the DRI and Maine's wage market basket for hospitals were used to trend rates. The minimum occupancy standard was set at 90%.

Adjustments

Adjustments upward during the rate period were made two to four times for sixty percent of facilities, while a retroactive upward adjustment was made for fifty percent of facilities. There was also and downward retroactive adjustment made for thirty percent of the facilities.

Cost Centers

Four cost centers are used for setting reimbursement rates in Maine: 1. Direct; 2. Indirect, limited at 115% of the median; 3. Routine, limited to 110% of the median; and 4. Fixed Cost. Operating costs are limited by the Medicare upper limit.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Maine. Five levels of care based on patient characteristics were provided. Case-mix will be implemented in FY1994.

Capital Costs

The value of capital is determined by historic cost. Actual Interest Expense was an allowable cost limited to the historical cost of a facility. Rental Costs and Leases was an allowable costs. The Rental Costs and Leases was limited to the cost of ownership. Depreciation was based on the straight line method. The American Hospital Guidelines were used for depreciation periods. Maine paid ten percent up to October 1992, then paid eight percent thereafter on net return on equity.

Reimbursement Rate

The 1993 average reimbursement rate for Maine was $87.00, calculated by days of care. Operating cost totaled $69.60, Ancillary Services were $3.48, and Capital was 13.92.

Other Long-Term Care

Maine uses the same system for hospital-based as for free-standing nursing facilities, averaging a per diem rate about 25% higher. It uses the same method to set ICF-MR rates, which average almost three-times higher than for free-standing nursing facilities. Home health rates are set using a prospective agency-specific system that pays the same average rate ($52.26) for RN as for home health aide visits. Adult day care is paid under waivers, using a retrospective flat rate.

[1] Capital is retrospective with an interim rate. Because of the interim rate the method is considered to be prospective.

MAINE

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$87.00
Percentage Rate Change From Previous Year	-0.28%
Peer Groupings	Free-Standing Nursing Facilities Separated from Hospital-Based Nursing Facilities
Year of Cost Report to Set Rate	1990
Inflation Adjustment	DRI & ME Wage Market Basket for Hospitals
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	Case-Mix Demonstration
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Durable Med. Equip. Patient Transport Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Reimbursement Rate	Generally 10% Higher than Free-Standing Nursing Facilities

ICF-MR

Method	Combination, Prospective Portion: Staffing & Fixed
Average Reimbursement Rate	$187.00
Ancilary Services Included in Rate	
State Facilities	Same as Free-Standing Nursing Facilities
Private Facilities	Non-Perscription Drug Medical Supplies Durable Med. Equip.

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$73.39
Average Reimbursement Rate, HH Aide Visit	$36.45

Other Residential Care For Aged

Method	Retrospective Facility-Specific (limited by routine service ceiling)
Average Rate: Residential Facility	$32.50/Day
Clients Covered	Developmentally Disabled

Adult Day Care

Method	Prospective Contract Negotiation
Average Rate: Aged and Physically Disabled	$6.00/Hour

Sub-Acute Care

Method	Prospective Patient/Facility-Specific
Average Rate: Head Injury	$359.89- $456.02

MARYLAND

Nursing Homes

The number of nursing homes in Maryland has been steadily increasing, from 175 in 1978 to 229 in 1993. The number of beds has also been steadily increasing, from 19,322 in 1978 to 28,850 in 1993. The ratio of beds per 1000 population aged 65 and over almost equalled the national average in 1993 (52.5 compared to 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Maryland has declined since 1989, from 11 facilities to 5 in 1993. The number of beds has been rapidly declining, from 1,819 in 1989 to 1,325 in 1993. There were 265 beds per facility in 1993, the third highest ratio of beds per facility in the country.

Other Residential Care

Maryland licenses domicilary care and sheltered homes. There were 732 of these facilities with 6,100 beds in 1993 (these numbers do not include residential care for the physically or mentally disabled). There was an average of 8.3 beds per facility in 1993, about half the national average.

Adult Day Care and Home Health Care

There were 88 licensed adult day care facilities in Maryland in 1993, a growth of 6 since 1992. There have been 100 licensed home care agencies since 1989, all of them certified in 1993.

CON/Moratorium

Maryland had a CON for nursing homes from 1978 through 1992 but dropped it in 1993. In 1993 there was neither a CON nor moratorium on hospital bed conversion, ICF/MRs, home health care, or residential care.

MARYLAND

Demographics

Percentage Population 65 and Over	11 % (US 12.7%)
Percentage Population 85 and Over	1.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	229
Total Beds	28850
Beds Per Nursing Home	126
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	52.5 (US 53.0)
Age 85 and Over	525 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.51 (US 6.2)
Expenditures Per 1000 Pop, 1992	$75,999 (US $92,314)
Adequacy of Bed Supply	Not Available

Intermediate Care For Mentally Retarded

Total Facilities	5
Total Beds	1325
Beds Per Facility	265
Beds Per 1000 Population	0.27 (US 0.53)

Other Residential Care For Aged

Total Facilities	732
Total Beds	6100
Beds Per Facility	8.3
Beds Per 1000 Pop, Age 65+	11.11 (US 19.6)

Adult Day Care For Aged

Total Facilities	88
Facilities Per 1000 Pop, Age 65+	0.16 (US 0.10)

Home Health Care Agencies

Total Agencies	100
Agencies Per 1000 Pop, Age 65+	0.18 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.05 (US 3.6)
Expenditures Per 1000 Pop, 1992	$8,729 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	No CON nor Moratorium
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

MARYLAND

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on both facility-specific and patient-specific rates. The method employed the peer grouping of patients by regions. The basic reimbursement method was adopted in 1983 when case-mix was adopted. A state fiscal year was used to set and re-base rates annually beginning July 1. The 1991 cost report used was for 1993. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 95%.

Adjustments

Adjusted by an interim rate then settled at cost.

Cost Centers

Four cost centers were used for setting reimbursement rates: 1. Nursing Service; 2. Administrative/Routine, limited to a ceiling of 106% of the median by bed size; 3. Other Patient Care limited to a ceiling of 112% of the median by region; and 4. Capital.

Ancillary Services

Physical Therapy, Occupational Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, Physician Services and Oxygen were included in the rate as allowable costs.

Case-Mix Adjusters

Case-mix was adopted in 1983. The Nursing Services portion of the rate is based on individuals. Patient measure was based on ADL's. Only the Direct Nursing Care is Case-mix adjusted. Four levels of care were provided.

Capital Costs

The value of capital is determined Appraisal/Reappraisal as a Fair Rental System. One third of the homes were appraised every four years or upon renovation. The maximum allowed appraised value is $35000.00 per bed. A Return-on-Equity was provided at 4.59 multiplied by the appraised ceiling.

Reimbursement Rate

The 1993 reimbursement rate for Maryland was $79.33, by mean of appraised value.

Other Long-Term Care

Maryland uses the same system to pay hospital-based nursing facilities as free-standing nursing facilities, but uses retrospective patient- or facility-specific rates for ICF-MRs, which are paid almost three times as much on average per diem as are nursing facilities. Home health payment uses Medicare principles with state alterations. Adult day care is paid using prospective flat rates.

MARYLAND

Free-Standing Nursing Facilities

Method	Prospective Patient/Facility-Specific, Adjusted
Average Reimbursement Rate	$79.33
Percentage Rate Change From Previous Year	2.33%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1991
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	95%
Case-Mix Adjusters	Diagnosis-Related Indicator Direct Nursing Portion of Rate Adjusted
Capital Reimbursement Determination	Appraisal as Fair Rental
Ancillary Services Included in Rate	

Physical Therapy	Non-Prescription Drug
Occupational Therapy	Durable Med. Equip.
Medical Supplies	Patient Transport
Physician Services	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Patient/Facility-Specific
Average Reimbursement Rate	$238.66
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Physician Services	

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$80-85.00 Flat Rate (estimate)
Average Reimbursement Rate, HH Aide Visit	$50.00 Flat Rate (estimate)

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	MD State Program
Average Rate by Service	$47.19 Flat Rate (6 days/week for 4 hours/day)

Sub-Acute Care

No Separate Program

MASSACHUSETTS

Nursing Homes

The number of nursing homes in Massachusetts has fluctuated but has shown an overall decline from 584 in 1978 to 566 in 1993. The number of beds fluctuated between 1978 and 1983 but has been growing steadily since then to a total of 53,479 in 1993. The ratio of beds per 1000 population aged 65 and over was greater than the national ratio in 1993 (63.5 compared to 53.0).

Intermediate Care for Mentally Retarded

ICF/MR facilities in Massachusetts are "certified" rather than licensed. In 1993 there were 92 "certified" facilities with 473 beds, a ratio of 5.1 beds per facility - the smallest ratio in the country.

Other Residential Care

The numbers of rest homes and beds in Massachusetts have been slowly declining, from 184 facilities with 5,959 beds in 1990 to 170 facilities with 5,625 beds in 1993. The 1993 bed per facility ratio was 33.1, just about two times the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Massachusetts. Home care is not licensed but there were 160 certified home care agencies in 1993.

CON/Moratorium

Massachusetts had a CON for nursing homes from 1978 through 1993, with a moratorium added to it in 1991, 1992, and 1993. In 1993 there was a CON/moratorium on hospital bed conversion but neither a CON nor moratorium on ICF/MRs, residential care, or home health care. There were 28 CON applications for nursing homes in 1993, none of which were denied.

MASSACHUSETTS

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.7 % (US 1.4%)

Nursing Home Facilities

Total Facilities	566
Total Beds	53479
Beds Per Nursing Home	94.5
Average Occupancy Rate	96.3
Beds Per 1000 Population:	
Age 65 and Over	63.5 (US 53.0)
Age 85 and Over	520.1 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.39 (US 6.2)
Expenditures Per 1000 Pop, 1992	$186184 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	92[1]
Total Beds	473[1]
Beds Per Facility	5.1
Beds Per 1000 Population	0.08 (US 0.53)

Other Residential Care For Aged

Total Facilities	170
Total Beds	5625
Beds Per Facility	33.1
Beds Per 1000 Pop, Age 65+	6.68 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.68 (US 3.6)
Expenditures Per 1000 Pop, 1992	$42,441 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

MASSACHUSETTS

Free-Standing Nursing Facilities

Methods

A prospective method was used to set Medicaid reimbursement for nursing facilities. This method was based on a facility-specific rate. The method employed level of care by region as a peer grouping. The basic reimbursement method was adopted in 1990. A calendar year was used to set rates annually. The 1989 re-basing effected FY1993. The 1989 Cost report was used for FY1993. The minimum occupancy standard was 96%.

Adjustments

No adjustments were made.

Cost Centers

Nine cost centers were used for setting reimbursement rates in Massachusetts: 1. Nursing, limited to 110% of mean by geographic location; 2. Administration and Policy Planning, limited by beds; 3. Working Capital; 4. Director of Nursing, limited by beds; 5. Incentive Based Variable, limited to 115% of the mean; 6. Non-incentive Based Variable, limited to 120% of the mean; 7. Motor vehicle, capped at $1500.00; and 8. Fixed costs and 9. Equity Allowance.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, and In house Physician were included in the rate. They are combined under the Variable cost center in the non-incentive component.

Case-Mix Adjusters

Case-mix was adopted in 1990. They used a Constant Minute focusing on ADL's as of July 1, 1991. Ten individual resident based rates (from direct Nursing cost center) were added to an average overall-facility rate.

Capital Costs

The value of capital was determined by historic cost and an imputed value. For capital-interest expense, nursing facilities used The Medicaid System. Refinancing and Renovation were allowable costs. Depreciation charges were allowed. Straight Line was used for depreciation set on a forty year period for buildings. A return on net equity for Profit facilities on fixed assets was allowed. The maximum rate of return allowable was 9.24%

Reimbursement Rate

The 1993 average reimbursement rate for Massachusetts was $96.04, calculated by days of care. The Operating portion of the rate was $90.76, and Capital was $4.80.

Other Long-Term Care

Massachusetts uses the same system for hospital-based as for free-standing nursing facilities, but only a prospective patient-specific method for ICF-MR. Home health agencies are paid on a fee schedule with a flat rate nearly three times higher ($55.76) for RN visits as for home health aide visits ($18.70). Adult day care is paid using a class method.

MASSACHUETTS

Free-Standing Nursing Facilities

Method	Prospective Patient/Facility-Specific
Average Reimbursement Rate	$96.04
Percentage Rate Change From Previous Year	-0.03%
Peer Groupings	Geographic Location (level of care by region)
Year of Cost Report to Set Rate	1989
Inflation Adjustment	Market Basket Indicator
Minimum Occupancy in Rate-Setting	96%
Case-Mix Adjusters	Acuity Measurement Direct Nursing Portion was Adjusted
Capital Reimbursement Determination	Historic Cost and Imputed Value
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Physician Services (in-house)

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Patient-Specific (excluded rentals & property value)
Private Facilities	Prospective Patient-Specific (cost-based)
Average Reimbursement Rate (all facilities)	$200.00 Plus (estimate)
Ancillary Services Included in Rate(all facilities)	Physical Therapy Occupational Therapy Respiratory Therapy Non-Prescription Drug Medical Supplies Patient Transport Physician Services

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$55.76
Average Reimbursement Rate, HH Aide Visit	$18.70

Other Residential Care For Aged

None

Adult Day Care

Method	Combination Class
Program	MA State Program
Average Rate: Day Health Facility	$30.65/Day
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care

No Separate Program

MICHIGAN

Nursing Homes

The number of nursing homes in Michigan has fluctuated since 1978, increasing from 447 in 1978 to 452 in 1993. The number of beds decreased from 1979 to 1982, increased to 51,813 in 1989, and has been decreasing since then to a total of 50,947 in 1993. The ratio of beds per 1000 population aged 65 and over was 43.5 in 1993, less than the national ratio of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Michigan has been steadily increasing, growing from 308 in 1989 to 481 in 1993. The number of beds dropped during two of those years but has shown an overall increase from 3,052 to 3,418. The ratio of ICF/MR beds per 1000 population is less than the national average (.36 compared to .53).

Other Residential Care

Michigan licenses two categories of residential care - adult foster care homes and homes for the aged. In 1993 there were 4,876 total facilities with 45,036 beds, the second highest number of facilities in the country. The bed per facility ratio in 1993 was 9.2, just greater than half the national ratio.

Adult Day Care and Home Health Care

Adult day care is not licensed in Michigan. Home care is not licensed but in 1993 there were 173 certified home care agencies.

CON/Moratorium

Michigan had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, residential care, and home health care. It did not cover ICF/MRs.

MICHIGAN

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.3 % (US 1.4%)

Nursing Home Facilities

Total Facilities	452
Total Beds	50947
Beds Per Nursing Home	112.7
Average Occupancy Rate	90.6
Beds Per 1000 Population:	
Age 65 and Over	43.5 (US 53.0)
Age 85 and Over	421.5 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.63 (US 6.2)
Expenditures Per 1000 Pop, 1992	$64,334 (US $92,314)
Adequacy of Bed Supply	Not Available

Intermediate Care For Mentally Retarded

Total Facilities	481
Total Beds	3418
Beds Per Facility	7.1
Beds Per 1000 Population	0.36 (US 0.53)

Other Residential Care For Aged

Total Facilities	4876
Total Beds	45036
Beds Per Facility	9.2
Beds Per 1000 Pop, Age 65+	38.47 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.41 (US 3.6)
Expenditures Per 1000 Pop, 1992	$20,222 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	CON Only
Home Health Care Agencies	CON Only
Day Care Agencies	CON Only

MICHIGAN

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of Number of Beds with ceiling limits for Administrative costs. The basic reimbursement method was adopted in 1985. A facility fiscal year was used to set annual rates. The 1991 Cost report was used for 1993. Inflation based on the DRI plus one percent for NFs. The minimum occupancy standard was set at 85% of available beds.

Adjustments

The rates were adjusted upward during the rate period four to five times for all facilities.

Cost Centers

Two cost components containing various cost centers are used for setting reimbursement rates in Michigan: 1. The Variable Base, having no limit, and containing: Nursing, Dietary, Nursing Administration, Utilities; and Laundry; and 2. Support, containing: Plant Operation, Administration and General, Housekeeping, and so on, limited by peer group and bed size to 80th percentile within peer group. A general limit on operating costs is set at 80 of median percentile utilization in industry (Support + Actual Cost).

Ancillary Services

Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Oxygen were included in the rate on an average per diem basis.

Case-Mix Adjusters

No case-mix adjusters were used in Michigan. One level of care is provided.

Capital Costs

The value of capital was determined by historic cost and a modified Rental Value, with Appraisals. Actual Interest Expense, subject to a ceiling valued capital-interest expenses. Refinancing, Refurbishing, were allowable costs. Depreciation charges were allowed for twelve percent of the facilities. The straight line method was used for depreciation. The American Hospital Guidelines were used for depreciation. Reimbursement was limited to $28,500 per bed.

Reimbursement Rate

The 1993 average reimbursement rate for Michigan is $67.12, calculated by days of care.

Other Long-Term Care

Michigan uses a similar method for hospital-based as for free-standing nursing facilities. It uses retrospective facility-specific payment for ICF-MRs, paying almost three-times as much per diem as for nursing facilities. Home health is paid under a fee schedule with flat rates, paying about 50% more for RN visits ($69.31) as for home health aide visits ($45.90). Sub-acute care is reimbursed using a prospective facility-specific method.

MICHIGAN

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$67.12
Percentage Rate Change From Previous Year	3.45%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	1991
Inflation Adjustment	DRI and 1% for Nursing Facilities
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost, Modified Rental Value and Appraisals
Ancillary Services Included in Rate	

Non-Prescription Drug	Medical Supplies
Durable Med. Equip.	Patient Transport
Oxygen	

Hospital-Based Nursing Facilities

Method	Similar to Free-Standing Nursing Facilities, but Limited to 80th Percentile of Hospital-Based Facilities.

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific (cost settled)
Private Facilities	Prospective Facility-Specific (contract)
Average Reimbursement Rate	
State Facilities	$195.00
Private Facilities	$96.00-$176.00
Peer Groupings (all facilities)	None
Capital Reimbursement Determination (all facilities)	Historic Cost
Ancillary Services Included in Rate	
All Facilities	

Respiratory Therapy	Medical Supplies
Non-Prescription Drug	Patient Transport

State Facilities Only	
Physical Therapy	Occupational Therapy
Oxygen	Durable Med. Equip.

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$69.31
Average Reimbursement Rate, HH Aide Visit	$45.90

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

Method	Prospective Facility-Specific
Average Rate: Ventilator	$285.00

MINNESOTA

Nursing Homes

The number of nursing homes in Minnesota has remained fairly constant, increasing from 442 in 1978 to 445 in 1993. The number of beds has remained fairly constant as well, hovering at about 45,000 since 1985 (44,887 in 1993). The ratio of beds per population aged 65 and over was 79.0 in 1993, one of the highest ratios in the country.

Intermediate Care for Mentally Retarded

There were 355 ICF/MR facilities with 5,774 ICF/MR beds in Minnesota in 1993. The ratio of ICF/MR beds per 1000 population in 1993 was 1.28, the third highest ratio in the country.

Other Residential Care

Minnesota has two categories of residential care - board and care and adult foster care (not including supervised living for the mentally ill or retarded, physically handicapped, or chemically dependent). The number of facilities and beds in these two categories has been growing steadily, with a 1993 total of 2,265 facilities with 12,520 beds. The average number of beds per facility was 5.5 in 1993, about 3 times less than the national average.

Adult Day Care and Home Health Care

There were 73 licensed adult day care facilities in Minnesota in 1993, a growth of 4 since 1992. There were 615 licensed home health care agencies in 1993, 218 of them certified.

CON/Moratorium

Minnesota had a CON for nursing homes between 1978 and 1982. In 1983 a moratorium was added and in 1984 the CON was removed. The moratorium on nursing homes has been in effect through 1993. In 1993 there was a moratorium on hospital bed conversion, ICF/MRs, and residential care. There was neither a CON nor moratorium on home health care. There has not been a CON or moratorium on home health care since at least 1978.

MINNESOTA

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.7 % (US 1.4%)

Nursing Home Facilities

Total Facilities	445
Total Beds	44887
Beds Per Nursing Home	100.9
Average Occupancy Rate	94.8
Beds Per 1000 Population:	
Age 65 and Over	79 (US 53.0)
Age 85 and Over	601.7 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.89 (US 6.2)
Expenditures Per 1000 Pop, 1992	$155200 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	355[1]
Total Beds	5774[1]
Beds Per Facility	16.3
Beds Per 1000 Population	1.28 (US 0.53)

Other Residential Care For Aged

Total Facilities	2265
Total Beds	12520
Beds Per Facility	5.5
Beds Per 1000 Pop, Age 65+	22.03 (US 19.6)

Adult Day Care For Aged

Total Facilities	73
Facilities Per 1000 Pop, Age 65+	0.13 (US 0.10)

Home Health Care Agencies

Total Agencies	615
Agencies Per 1000 Pop, Age 65+	1.08 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.63 (US 3.6)
Expenditures Per 1000 Pop, 1992	$26,692 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	Moratorium Only
Hospitial Bed Conversion	Moratorium Only
Residental Care Beds	Moratorium Only
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

[1] Estimate

MINNESOTA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on patient-specific and facility-specific rates. Geographic Location by region was used as a peer grouping. The basic reimbursement method was adopted in 1985 when Minnesota added case-mix. A state fiscal year was used to set annual rates beginning July 1. The September 1992 Cost reports were used for FY1993. Inflation based on the DRI was used to trend rates. The minimum occupancy standard was 85% for operating costs and 95% for property.

Adjustments

Not adjusted.

Cost Centers

Four cost centers were used for setting reimbursement rates: 1. Cost Related Costs, limited to 125% of the median; 2. Other Operating Costs, limited to 110% of the median; 3. Administration Costs, limits were variable, dependent on size of facility; 4. Property Costs.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Oxygen were included in the rate. These ancillary services were included under the appropriate cost center.

Case-Mix Adjusters

Case-mix was adopted in 1985. Minnesota used Resident Classes and Class Weights, rates set based on overall facility. Only the Direct Nursing Care component was Case-mix adjusted.

Capital Costs

The value of capital was determined by a combination of Historic Cost Appraisal and a Rental Value. For capital-interest expensed nursing facilities used the actual interest expense, subject to a ceiling. Refinancing, Renovation, and Rental Costs and Leases were allowable costs. Interest was capped. A limit was set on the maximum appraised value. The rental factor was 5.66, applied to an appreciating property base, based on a real rate of return.

Reimbursement Rate

The 1993 average reimbursement rate for Minnesota was $81.91, weighted by days of care. Operating costs including Ancillary Services included in the rate were $74.54 while the Capital portion was $7.37.

Other Long-Term Care

Minnesota uses the same system for hospital-based as for free-standing nursing facilities. It uses Medicare principles for state ICF-MR regional treatment centers and prospective facility-specific payment for private ICF-MRs. Home health agencies are paid using Medicare principles with state alterations, about one-third more ($48.83) for a RN visit as for a home health aide visit ($37.45). Other residential care for the aged is paid under waiver using a prospective patient-specific method. Sub-acute care is reimbursed using a combination facility-specific method.

MINNESOTA

Free-Standing Nursing Facilities

Method	Prospective Patient/Facility-Specific
Average Reimbursement Rate	$81.91
Percentage Rate Change From Previous Year	-0.18%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	September 1992
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	85% Operating & 95% Property
Case-Mix Adjusters	Resource-Based Measure; Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost, Appraisal, & Rental Value
Ancillary Services Included in Rate	Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Reimbursement Rate	Included in Free-Standing Nursing Facilities Rate

ICF-MR

Method	
State Facilities	Regional Treatment Centers Medicare Principles
Private Facilities	Prospective Facility-Specific by Geographical Groupings, Cost Settled
Average Reimbursement Rate	
State Facilities	Not Available
Private Facilities	$107.27
Capital Reimbursement Determination (private facilities)	Historic Cost

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$48.82
Average Reimbursement Rate, HH Aide Visit	$37.45

Other Residential Care For Aged

Method	Prospective Patient-Specific
Program	1915c & 2176 Waivers
Facility Type	Residential
Average Rate	$950.00/Year
Clients Covered	Aged & Physically Disabled

Adult Day Care

None

Sub-Acute Care

Method	Combination Facility-Specific
Average Rate: Ventilator:	$375.00/Day

MISSISSIPPI

Nursing Homes

The number of nursing homes has remained fairly constant in Mississippi, increasing from 158 in 1978 to 173 in 1993. The number of beds has fluctuated but has shown an increase from 11,424 in 1978 to 16,251 in 1993. The ratio of beds per 1000 population aged 65 and over was slightly less than the national ratio (49.4 compared to 53.0) in 1993.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Mississippi has remained constant at 12 since 1989, while the number of beds increased from 1,622 in 1989 to 1,970 in 1993. There was an average of 164.2 beds per facility in Mississippi in 1993, more than 7 times the national average.

Other Residential Care

Residential care has been growing rapidly in Mississippi, increasing from 79 facilities with 1,476 beds in 1989 to 124 facilities with 2,477 beds in 1993. The bed per facility ratio in 1993 was 20.0, about 4 beds higher than the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Mississippi. There were 81 licensed home health care agencies in 1993, all of them certified.

CON/Moratorium

Mississippi had a CON for nursing homes in 1979 and 1980 and added a moratorium to it in 1981. The joint CON/moratorium has been in effect through 1993. In 1993 the CON/moratorium also covered ICF/MRs, residential care, and home health care. A CON alone covered hospital bed conversion. There were 7 CON applications for nursing homes in 1993, 2 of which were denied.

MISSISSIPPI

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.5 % (US 1.4%)

Nursing Home Facilities

Total Facilities	173
Total Beds	16251
Beds Per Nursing Home	93.9
Average Occupancy Rate	96.1
Beds Per 1000 Population:	
Age 65 and Over	49.4 (US 53.0)
Age 85 and Over	410.4 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.24 (US 6.2)
Expenditures Per 1000 Pop, 1992	$77,731 (US $92,314)
Adequacy of Bed Supply	Under Supply

Intermediate Care For Mentally Retarded

Total Facilities	12
Total Beds	1970
Beds Per Facility	164.2
Beds Per 1000 Population	0.75 (US 0.53)

Other Residential Care For Aged

Total Facilities	124
Total Beds	2477
Beds Per Facility	20
Beds Per 1000 Pop, Age 65+	7.52 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	81
Agencies Per 1000 Pop, Age 65+	0.25 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.81 (US 3.6)
Expenditures Per 1000 Pop, 1992	$2,629 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON Only
Residental Care Beds	CON & Moratorium
Home Health Care Agencies	CON & Moratorium
Day Care Agencies	No CON nor Moratorium

MISSISSIPPI

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed a bed peer grouping. The basic reimbursement method was adopted in 1979. A state fiscal year was used to set and annual rates beginning July 1. The 1991 Cost reports were used for 1993. Inflation based on a Mississippi Market basket was used to trend rates. A minimum occupancy standard was set at 80%.

Adjustments

Rates were adjusted upward retroactively one time for ten to fifteen percent of facilities due to a change of ownership or a class change. The rate was adjusted downward during the rate period one time for all facility due to a legislative change.

Cost Centers

Cost centers used for setting reimbursement rates were: 1. Direct Care, 2. Therapy, 3. Care Related, 4. Administration and Operating, Property and Equity, and 6. Not Allowable.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Physician Services, Oxygen, and Patient Transportation were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Mississippi. Case-mix was set for implementation July 1 1994. One level of care was provided.

Capital Costs

The value of capital is determined by historic cost. For capital-interest expense, nursing facilities used, actual interest expense, subject to a ceiling. Rental Costs and Leases were allowable costs. The straight line method was used for depreciation. The American Hospital Guidelines were used for depreciation. A return on net equity of 7.5 was limited by the Medicare maximum rate of return.

Reimbursement Rate

The 1993 average reimbursement rate for Mississippi was $58.07[1]

Other Long-Term Care

Mississippi uses the same system for hospital-based as for free-standing nursing facilities and for ICF-MRs, which average nearly twice the per diem rate of free-standing nursing facilities. Home health care is reimbursed under Medicare principles, averaging almost twice the rate ($68.86) for a RN as for a home health aide visit ($35.81). Mississippi has no Medicaid coverage of residential care or of adult day care, and no separate sub-acute care program under Medicaid.

MISSISSIPPI

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$58.07[1]
Percentage Rate Change From Previous Year	4.74%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	1991
Inflation Adjustment	MS Market Basket
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusters	Case-Mix Demonstration
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Non-Prescription Drug	Medical Supplies
Durable Med. Equip.	Physician Services
Oxygen	Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$106.12
Ancillary Services Included in Rate	

Non-Prescription Drug	Physician Services
Medical Supplies	Oxygen
Patient Transport	

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$68.86
Average Reimbursement Rate, HH Aide Visit	$35.81

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

[1] **Estimate**

MISSOURI

Nursing Homes

The number of nursing homes in Missouri had been steadily increasing, from 456 in 1978 to 628 in 1992, but dropped to 614 in 1993. The number of beds had similarly been increasing, from 35,779 in 1978 to 57,415 in 1992, but dropped in 1993 to 57,321. The ratio of beds per 1000 population aged 65 and over was 77.3 in 1993, one of the highest ratios in the country.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Missouri has been declining over the last four years, from 41 in 1989 to 30 in 1993. The number of beds has shown a similar drop, from 2,035 beds in 1989 to 1,615 in 1993. The ratio of ICF/MR beds per 1000 population was .31 in 1993, substantially less than the U.S. average of .53.

Other Residential Care

Missouri designates its residential care by residential care facility 1 and residential care facility 2. In 1993 there were 614 total residential care facilities with 17,037 beds, an average of 27.7 beds per facility - 11 beds greater than the national average.

Adult Day Care and Home Health Care

The number of adult day care facilities has doubled in Missouri, growing from 17 facilities in 1989 to 35 in 1993. Licensed home care agencies grew from 192 in 1989 to 233 in 1992 before dropping to 214 in 1993.

CON/Moratorium

Missouri had a CON for nursing homes between 1980 and 1982 and added a moratorium to it in 1983. The CON/moratorium has been in effect through 1993. In 1993 the CON/moratorium also covered hospital bed conversion and ICF/MRs. There was neither a CON nor moratorium on residential care or home health care. There were 24 CON applications for nursing homes in 1993, 8 of which were denied.

MISSOURI

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.8 % (US 1.4%)

Nursing Home Facilities

Total Facilities	614
Total Beds	57321
Beds Per Nursing Home	93.4
Average Occupancy Rate	82.3
Beds Per 1000 Population:	
Age 65 and Over	77.3 (US 53.0)
Age 85 and Over	627 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.66 (US 6.2)
Expenditures Per 1000 Pop, 1992	$71,231 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	30
Total Beds	1615
Beds Per Facility	53.8
Beds Per 1000 Population	0.31 (US 0.53)

Other Residential Care For Aged

Total Facilities	614
Total Beds	17037
Beds Per Facility	27.7
Beds Per 1000 Pop, Age 65+	22.98 (US 19.6)

Adult Day Care For Aged

Total Facilities	35
Facilities Per 1000 Pop, Age 65+	0.05 (US 0.10)

Home Health Care Agencies

Total Agencies	214
Agencies Per 1000 Pop, Age 65+	0.29 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.72 (US 3.6)
Expenditures Per 1000 Pop, 1992	$5,994 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

MISSOURI

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in July of 1990. A state fiscal year is used to set annual rates beginning July 1. Costs from 1988 cost reports were the original basis for setting the rate. Inflation based on DRI were used to trend rates. The minimum occupancy standard was set at 90%.

Adjustments

The rates were adjusted upward retroactively five times for one percent of Medicaid facilities. The rates were adjusted downward during the rate period five to ten times for one percent of facilities.

Cost Centers

No cost centers were used for setting reimbursement rates in Missouri.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Missouri. Case-mix was set for implementation October 1, 1994. One level of care was provided.

Capital Costs

The value of capital was determined by historic cost. For capital interest expense, nursing facilities used actual interest. Refinancing, Renovation, and Rental Costs and Leases were allowable costs. The straight line method was used for depreciation. The average return on net equity allowed was limited to twelve percent, based on for profit facilities.

Reimbursement Rate

The 1993 average reimbursement rate for Missouri was $57.93, weighted by number of facilities.

Other Long-Term Care

Missouri uses the same system for hospital-based as for free-standing nursing facilities, and a retrospective method for ICF-MR. Home health is reimbursed using Medicare principles with state alterations, paying the same average rate for a RN visit as for a home health aide visit ($57.34). Adult day care is paid using a prospective flat rate methodology.

MISSOURI

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$57.93
Percentage Rate Change From Previous Year	9.52%
Peer Groupings	None
Year of Cost Report to Set Rate	1988
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Oxygen	

Hospital-Based Nursing Facilities

Method — Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific
Private Facilities	Prospective Facility-Specific
Average Reimbursement Rate (all facilities)	Not Available
Ancillary Services Included in Rate (all facilities)	Same as Free-Standing Nursing Facilities

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$57.34
Average Reimbursement Rate, HH Aide Visit	$57.34

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	Not Available
Facility Type	Day Health
Average Rate	$32.00 per diem
Clients Covered	Aged; Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care

No Separate Program

MONTANA

Nursing Homes

The number of nursing homes in Montana increased from 92 in 1978 to 100 in 1989 before decreasing to 95 in 1993. The number of beds has fluctuated, increasing from 6,270 in 1978 to 6,911 in 1989 and decreasing again to 6,465 in 1993. Bed growth between 1978 and 1993 was 3.1%, one of the smallest growth rates in the country.

Intermediate Care for Mentally Retarded

Montana has had 3 ICF/MR facilities with 188 ICF/MR beds since 1990. The ratio of beds per 1000 population in 1993 was .22, less than half the national ratio of .53.

Other Residential Care

The number of residential care facilities in Montana remained constant at 148 between 1990 and 1993, while the number of beds increased from 813 to 921. The average number of beds per facility in 1993 was 6.2, about 10 beds less than the national average.

Adult Day Care and Home Health Care

Montana has had 25 licensed adult day care facilities since 1990. There were 48 licensed home care agencies in 1993, up from 40 in 1990.

CON/Moratorium

Montana has had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. There were 2 CON applications for nursing homes in 1993, neither one of which was denied.

MONTANA

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.5 % (US 1.4%)

Nursing Home Facilities

Total Facilities	95[1]
Total Beds	6465[1]
Beds Per Nursing Home	68.1
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	57.3 (US 53.0)
Age 85 and Over	532.4 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.54 (US 6.2)
Expenditures Per 1000 Pop, 1992	$84,156 (US $92,314)
Adequacy of Bed Supply	Under Supply

Intermediate Care For Mentally Retarded

Total Facilities	3[1]
Total Beds	188[1]
Beds Per Facility	62.7
Beds Per 1000 Population	0.22 (US 0.53)

Other Residential Care For Aged

Total Facilities	148[1]
Total Beds	921[1]
Beds Per Facility	6.2
Beds Per 1000 Pop, Age 65+	8.17 (US 19.6)

Adult Day Care For Aged

Total Facilities	25
Facilities Per 1000 Pop, Age 65+	0.22 (US 0.10)

Home Health Care Agencies

Total Agencies	48[1]
Agencies Per 1000 Pop, Age 65+	0.43 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	0.73 (US 3.6)
Expenditures Per 1000 Pop, 1992	$1,109 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

MONTANA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employs no peer groupings. The basic reimbursement method was adopted in 1991. A state fiscal year was used to set annual rates beginning July 1. The 1991 cost reports were used for 1993. Inflation based on the DRI-SNF was used to trend rates. A minimum occupancy standard was not used to set rates.

Adjustments

Adjustments were made upward during and retroactively a single time for all facilities. Rates were also adjusted downward during and retrospectively nine times for ten percent of the facilities.

Cost Centers

Four cost centers were used for setting reimbursement rates: 1. Direct Nursing, limited to 125% of median; 2. Property, limited to $9.47; 3. Operating, limited to 110% of the median; and 4. Operating Incentive equal to the lesser of five percent of median operating cost or forty percent of the difference between the cap and facility operating cost per day.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, and Patient Transportation, were included in the operating portion of the rate.

Case-Mix Adjusters

Case-mix was adopted in 1985. The Tennessee National Health Corporation Abstract System, based on an ADL formula converted to minutes is used in the case-mix system. Individual based rate formulas are aggregated into and Overall-facility basis for reimbursement. Only the Direct Nursing Care portion of the rate is case-mixed.

Capital Costs

The value of capital was determined by Historic Cost and an imputed Rental Value based on age and type of construction. For capital interest expenses, nursing facilities used actual interest. Financing, Renovation and Rental Costs and Leases were allowable costs. American Hospital Guidelines were used for depreciation and the straight line method was used.

Reimbursement Rate

The 1993 average reimbursement rate for Montana was $69.69, weighted by days of care. On average, the Operating rate was $34.00 and Capital was $5.94.

Other Long-Term Care

Montana uses the same system for hospital-based as for free-standing nursing facilities, and a retrospective method to set ICF-MR rates, which average over three-times as high as for free-standing nursing facilities. Home health services are paid the lower of a retrospective and a prospective rate, averaging twice as much ($47) for a RN visit as for a home health aide visit ($24). Adult day care is covered under waivers, using a prospective patient-specific method. Sub-acute care also uses a prospective patient-specific method.

MONTANA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$69.69
Percentage Rate Change From Previous Year	10.23%
Peer Groupings	None
Year of Cost Report to Set Rate	1991
Inflation Adjustment	DRI-SNF
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	TNCA[1] System, Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost and Rental Value
Ancillary Services Included in Rate	
	Non-Prescription Drug Medical Supplies
	Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$221.86
Cost Centers	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Lower of Retrospective/Prospective
Average Reimbursement Rate, RN Visit	$47.00[2]
Average Reimbursement Rate, HH Aide Visit	$24.00

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Patient-Specific
Reimbursement Program	2176 & 1915c Waivers
Average Rate by Facility	
Social (Aged)	$3.60/Hour
Habitation (Physically Disabled)	$30.32/Day

Sub-Acute Care

Method	Prospective Patient-Specific
Average Rate: Traumatic Brain Injury	$129.00

[1] Tennessee National Corporation Abstract (TNCA) System.
[2] Unweighted average by grouping.

NEBRASKA

Nursing Homes

The number of nursing homes in Nebraska has remained fairly constant, increasing only from 225 in 1978 to 243 in 1993. Bed growth has been slow, increasing from 18,284 in 1978 to 19,513 in 1993. The ratio of beds per 1000 population aged 65 and over in Nebraska was 85.3 in 1993, the highest ratio in the country.

Intermediate Care for Mentally Retarded

Nebraska had 5 ICF/MR facilities in 1993, an increase of 1 since 1989. The number of ICF/MR beds grew with the increase of the new facility from 798 to 864. Nebraska had an average of 172.8 beds per facility in 1993, more than 7 times the national average.

Other Residential Care

There are two categories of residential care in Nebraska - residential care and domicillary care. In 1993 there was a total of 99 facilities with 4,119 beds. The average number of beds per facility in 1993 was 41.6, almost 3 times the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Nebraska. The number of home health care agencies had been steadily increasing, from 69 in 1989 to 101 in 1992, but dropped to 99 in 1993.

CON/Moratorium

Nebraska had a CON for nursing homes from 1979 though 1993. In 1993 the CON also covered hospital bed conversion and ICF/MRs. It did not cover residential care or home health care. There was 1 CON application submitted and accepted for a nursing home in 1993.

NEBRASKA

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	2.0 % (US 1.4%)

Nursing Home Facilities

Total Facilities	243
Total Beds	19513
Beds Per Nursing Home	80.3
Average Occupancy Rate	91.2
Beds Per 1000 Population:	
Age 65 and Over	85.3 (US 53.0)
Age 85 and Over	621.6 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.81 (US 6.2)
Expenditures Per 1000 Pop, 1992	$99,663 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	5
Total Beds	864
Beds Per Facility	172.8
Beds Per 1000 Population	0.54 (US 0.53)

Other Residential Care For Aged

Total Facilities	99
Total Beds	4119
Beds Per Facility	41.6
Beds Per 1000 Pop, Age 65+	18 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	99
Agencies Per 1000 Pop, Age 65+	0.43 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.69 (US 3.6)
Expenditures Per 1000 Pop, 1992	$7,424 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

NEBRASKA

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of Geographic Location by urban/rural by OBRA 87 staffing standards. The basic reimbursement method was adopted July 1 1992 when Nebraska added case-mix. A state fiscal year is used to set annual rates beginning July 1. The 1992 cost reports were used for setting the FY1993 rates. The CPI was used to trend rates. The minimum occupancy standard was set at 85%.

Adjustments

Adjustments were made to the interim rate at cost settlement.

Cost Centers

Four cost centers were used for setting reimbursement rates in Nebraska: 1. Direct Nursing of which Salaries and benefits, limited to 125% of median for facility's peer grouping; 2. Direct Support, Nursing Minutes limited to 115% of the median for facility's peer grouping; 3. Other Support, limited to 115% of the median for facility's peer grouping; and 4. Fixed Cost.

Ancillary Services

Respiratory Therapy, Medical Supplies, Oxygen, and Patient Transportation were included in the rate.

Case-Mix Adjusters

Case-mix was adopted in 1992 based on RUGs III. The rates were based on facility cost but set at the individual level. Only the Direct Nursing Care was case-mixed. Nineteen levels of care were provided.

Capital Costs

The value of capital was determined by historic cost. For capital interest expenses, nursing facilities used actual interest expense. Refinancing (subject to Medicare), Renovation, and Rentals Costs and Leases[2] were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for Nebraska was $60.07, weighted by number of facilities by peer group.

Other Long-Term Care

Nebraska uses the same system for hospital-based as for free-standing nursing facilities, and a straight prospective facility-specific method, without adjustments, to set ICF-MR rates, which average over twice those for free-standing nursing facilities. Home health services are paid under a fee schedule with flat rates, paying 75% more ($73.50) for a RN visit as for a home health aide visit ($43). Adult day care is paid under waiver, using a prospective flat rate. Sub-acute care is reimbursed using retrospective rates.

[1] NE had a retrospective method with an interim rate therefore it was re-categorized prospective.

[2] Payments for leases entered into after 1984 were paid at the lower of actual lease cost or the actual fixed costs of the lessor.

NEBRASKA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$60.07
Percentage Rate Change From Previous Year	-0.18%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1991
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	RUGS III; Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	
	Respiratory Therapy — Oxygen
	Medical Supplies — Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method (all facilities)	Prospective Facility-Specific (no peer group)
Average Reimbursement Rate	
State Facilities	$151.32
Private Facilities	$132.41
Ancillary Services Included in Rate	
State Facilities	Included All Ancillary Services
Private Facilities	Physical Therapy — Occupational Therapy
	Respiratory Therapy — Medical Supplies
	Durable Med. Equip. — Patient Transport
	Oxygen

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$73.50
Average Reimbursement Rate, HH Aide Visit	$43.00

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Flat Rate
Program	2176 Waiver
Facility Type	Day Health and Dementia/Alzheimers Disease
Clients Covered	Aged & Physically Disabled and AIDS/HIV
Flat Rate	$19.50/Day

Sub-Acute Care

Method	Retrospective Facility-Specific
Average Rates	
Ventilator	$450.00 - $522.00
Medically Complex Subacute	$379.00

NEVADA

Nursing Homes

The number of nursing homes in Nevada has been growing slowly, increasing from 25 in 1978 to 35 in 1993. The number of beds has fluctuated but has grown from 2,009 in 1978 to 3,623 in 1993. The ratio of beds per 1000 population aged 65 and over was 23.4 in 1993, the smallest ratio in the country.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Nevada has been steadily growing, increasing from 3 in 1989 to 11 in 1993. The number of beds has increased at a slower pace, growing from 193 in 1990 to 211 in 1993. The ratio of ICF/MR beds per 1000 population in 1993 was .15, substantially less than the national average of .53.

Other Residential Care

Residential care in Nevada is licensed as adult group care. The number of these facilities remained constant between 1990 and 1992, increasing only from 175 to 178 facilities, but by 1993 there were 203 facilities. There were 1,887 beds in 1993, an average of 9.3 beds per facility - almost half the national average.

Adult Day Care and Home Health Care

Nevada had 11 adult day care facilities in 1993. There were 51 licensed home care agencies, 28 of them certified, in 1993.

CON/Moratorium

Nevada had a CON for nursing homes from 1978 through 1993; however, in 1991, the law changed to exempt from CON the two largest counties in the state (in which over 80% of the population resides). In 1993 a CON also covered hospital bed conversion and ICF/MRs, while there was no CON or moratorium on residential care or home health care. There was 1 CON application submitted and approved for nursing homes in 1993.

NEVADA

Demographics

Percentage Population 65 and Over	11 % (US 12.7%)
Percentage Population 85 and Over	0.7 % (US 1.4%)

Nursing Home Facilities

Total Facilities	35
Total Beds	3623
Beds Per Nursing Home	103.5
Average Occupancy Rate	90.4
Beds Per 1000 Population:	
Age 65 and Over	23.4 (US 53.0)
Age 85 and Over	359.6 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.56 (US 6.2)
Expenditures Per 1000 Pop, 1992	$39,691 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	11
Total Beds	211
Beds Per Facility	19.2
Beds Per 1000 Population	0.15 (US 0.53)

Other Residential Care For Aged

Total Facilities	203
Total Beds	1887
Beds Per Facility	9.3
Beds Per 1000 Pop, Age 65+	12.21 (US 19.6)

Adult Day Care For Aged

Total Facilities	11
Facilities Per 1000 Pop, Age 65+	0.07 (US 0.10)

Home Health Care Agencies

Total Agencies	51
Agencies Per 1000 Pop, Age 65+	0.33 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.23 (US 3.6)
Expenditures Per 1000 Pop, 1992	$8,060 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

NEVADA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted January 1 1988. A state fiscal year was used to set annual rates beginning July 1. The 1990 Cost reports were used for setting the FY1993 rates. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 92% on the property portion of the rate only.

Adjustments

No adjustments were made to the initial rate.

Cost Centers

Five cost centers were used for setting the prospective portion of the reimbursement rate in Nevada: 1. Housekeeping; 2. Administration; 3. Raw Foods; 4. Health Care; and 5. Employee salaries. Within particular cost centers there may be limitations, such as $40,000.00 for a director's salary.

Ancillary Services

Non-Prescription Drugs, and Medical Supplies were included in the rate.

Case-Mix Adjusters

Case-mix was adopted in the early 1980s. There were six levels of care based on skill need and minimum and maximum nursing care time. Only the Direct Nursing Care portion of the rate was case-mixed.

Capital Costs

The value of capital was determined by Historic Cost. For capital interest expenses, nursing facilities used the actual interest, subject to a ceiling. Financing, Renovation, and Rental Cost and Leases were allowable costs.

Reimbursement Rate

The 1993 average reimbursement rate for Nevada was $75.85.

Other Long-Term Care

Nevada uses a retrospective method to pay hospital-based nursing facilities, as it also does to pay ICF-MRs. Home health payment uses a fee schedule with flat rates, much higher for RN visits ($62) than for home health aide visits ($20). Adult day care is paid using retrospective flat rates.

NEVADA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$75.85
Percentage Rate Change From Previous Year	10.60%
Peer Groupings	None
Year of Cost Report to Set Rate	1990
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	92% (property)
Case-Mix Adjusters	Acuity Measure Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug & Medical Supplies

Hospital-Based Nursing Facilities

Method	Retrospective
Average Reimbursement Rate	Not Available

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	Not Available
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$52.00
Average Reimbursement Rate, HH Aide Visit	$20.00

Other Residential Care For Aged

None

Sub-Acute Care

Method	Retrospective Flat Rate
Program (day health)	Rehabilitative Option Under State Plan
Average Rate: Social or Day Health	$25.00/Day (6 hours)
Clients Covered	Aged; Physically & Developmentally Disabled; Mentally Ill

NEW HAMPSHIRE

Nursing Homes

The number of nursing homes in New Hampshire remained fairly constant between 1978 and 1988, increasing from 66 to 70 facilities. In 1992 that number had grown to 80 facilities, but by 1993 had dropped to 78. The number of beds has fluctuated but has shown an overall increase from 5,952 in 1978 to 7,240 in 1993. The ratio of beds per 1000 population aged 65 and over was 54.0 in 1993, just greater than the national ratio.

Intermediate Care for Mentally Retarded

New Hampshire had 8 ICF/MR facilities with 84 ICF/MR beds from 1989 to 1992. In 1993 there were 4 facilities with 48 beds, the fewest ICF/MR beds in the country. The state is increasingly making use of waivers and hopes to be down to 2 ICF/MRs for the severest patients in the next year or two.

Other Residential Care

New Hampshire licenses residential care for the elderly in residential care home facilities and supported residential care facilities. There were 135 total facilities with 2,374 beds in 1993. The average number of beds per facility in 1993 was 17.6, about a bed greater than the national average.

Adult Day Care and Home Health Care

The number of adult day care centers in New Hampshire has been growing slowly, increasing from 5 in 1989 to 12 in 1993. The number of licensed home care agencies had been growing somewhat faster, increasing from 87 in 1989 to 102 in 1992, but then dropped to 91 in 1993 as some categories of care previously counted as home health were separated into their own categories (for example, case management services and high-tech home health care).

CON/Moratorium

New Hampshire had a CON for nursing homes from 1979 through 1993. In 1993 the CON did not cover hospital bed conversion, ICF/MRs, residential care, or home health care. There were no new CON applications for nursing homes in 1993.

NEW HAMPSHIRE

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	78
Total Beds	7240
Beds Per Nursing Home	92.8
Average Occupancy Rate	94.8
Beds Per 1000 Population:	
Age 65 and Over	54 (US 53.0)
Age 85 and Over	461.1 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.82 (US 6.2)
Expenditures Per 1000 Pop, 1992	$136050 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	4
Total Beds	48
Beds Per Facility	12
Beds Per 1000 Population	0.04 (US 0.53)

Other Residential Care For Aged

Total Facilities	135
Total Beds	2374
Beds Per Facility	17.6
Beds Per 1000 Pop, Age 65+	17.71 (US 19.6)

Adult Day Care For Aged

Total Facilities	12
Facilities Per 1000 Pop, Age 65+	0.09 (US 0.10)

Home Health Care Agencies

Total Agencies	91
Agencies Per 1000 Pop, Age 65+	0.68 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.31 (US 3.6)
Expenditures Per 1000 Pop, 1992	$52,248 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

NEW HAMPSHIRE

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed bed size (1-99,100+) for peer grouping. The basic reimbursement method was adopted in 1987. A state fiscal year is used to set annual rates beginning October 1. The May 1992 Cost reports were used for 1993. Inflation based on the CPI, all items, was used to trend rates. The minimum occupancy standard was 85%.

Adjustments

Adjustments to the initial rates were made upward/downward during the rate period. Rates were changed by appeal.

Cost Centers

Four cost centers are used for setting reimbursement rates in New Hampshire: 1. Patient Care; 2. Administration; and 3. Support Costs; 4. Capital. 1, 2, and 3 have an upper limit of 75% established within peer groups for six categories.

Ancillary Services

Physical Therapy, Occupational Therapy, Medical Supplies, Durable Medical Equipment, Patient Transportation, Oxygen and were included in the rate. Ancillaries are part of Patient Care.

Case-Mix Adjusters

No case-mix adjusters were used in New Hampshire. One level of care was provided.

Capital Costs

The value of capital is determined by Historic Cost and a Rental Value. For capital interest expenses, nursing facilities used the actual interest expense. Refinancing, Renovation, and Rental Cost and Leases were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for New Hampshire was $98.94, weighted by days of care.

Other Long-Term Care

New Hampshire uses the same system for hospital-based as for free-standing nursing facilities, but a retrospective method for ICF-MRs, which average almost three-times as much per diem as do nursing facilities. Home health agencies are paid using Medicare principles.

Other residential care for the aged is paid under waiver using a retrospective method. Adult day care is reimbursed using a retrospective system. Subacute payment employs a prospective facility-specific method.

NEW HAMPSHIRE

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$98.94
Percentage Rate Change From Previous Year	3.5%
Peer Groupings	Bed Size
Year of Cost Report to Set Rate	May 1992
Inflation Adjustment	CPI (all items)
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost and Rental Value
Ancillary Services Included in Rate	Physical Therapy, Respiratory Therapy, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$287.00
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Durable Med. Equip., Patient Transport, Prescription Drug, Oxygen, Physician Services

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

Method	Retrospective Flat Rate
Program	1115 Waiver
Facility Type	Group and Residential
Average Rate	$640.00/Month
Clients Covered	Aged; Physically & Developmentally Disabled; Mentally Ill; Pediatric

Adult Day Care

Method	Retrospective Facility-Specific
Program	Not Available
Facility Type	Day Health and Dementia/Alzheimers Disease
Clients Covered	Aged; Physically & Developmentally Disabled; Mentally Ill; Pediatric
Average Rate for All	$16.50 (five hour day)

Sub-Acute Care

Method	Prospective Facility-Specific
Average Rate: Aged & Physically Disabled	$315.00

NEW JERSEY

Nursing Homes

The number of nursing homes in New Jersey fluctuated between 1978 and 1993, showing an overall increase from 188 facilities in 1978 to 355 in 1993. There were 48,720 nursing home beds in New Jersey in 1993, a ratio of beds per 1000 population aged 65 and over of 45.5 (less than the U.S. ratio of 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in New Jersey has remained fairly constant, maintaining at 11 between 1989 and 1991 but decreasing to 10 in 1992 and 8 in 1993. The number of ICF/MR beds has remained constant as well, decreasing by only a few beds over the five year period (3,789 beds in 1989; 3,676 in 1993). The average number of beds per facility in New Jersey was 459.5 in 1993, the largest bed per facility average in the country.

Other Residential Care

There are two categories of residential care in New Jersey - residential health care and boarding homes (divided into different "classes"). There were 414 total facilities with 11,801 beds in 1993, a drop of 21 facilities and 625 beds since 1992. The bed per facility ratio in 1993 was 28.5, about 12 beds higher than the national ratio.

Adult Day Care and Home Health Care

The number of adult day care facilities in New Jersey has been slowly increasing, growing from 59 in 1989 to 71 in 1993. Home health care has been growing at a slower pace, increasing from 66 agencies in 1989 to 71 in 1993.

CON/Moratorium

New Jersey had a CON for nursing homes from 1978 through 1993, adding a moratorium to it between 1991 and 1992. In 1993 the CON also covered hospital bed conversion, residential care, and home health care. There was neither a CON nor moratorium on ICF/MRs. There were 35 CON applications for nursing homes in 1993, 6 of which were denied.

NEW JERSEY

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	355
Total Beds	48720
Beds Per Nursing Home	137.2
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	45.5 (US 53.0)
Age 85 and Over	439.1 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.96 (US 6.2)
Expenditures Per 1000 Pop, 1992	$109733 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	8
Total Beds	3676
Beds Per Facility	459.5
Beds Per 1000 Population	0.47 (US 0.53)

Other Residential Care For Aged

Total Facilities	414
Total Beds	11801
Beds Per Facility	28.5
Beds Per 1000 Pop, Age 65+	11.02 (US 19.6)

Adult Day Care For Aged

Total Facilities	71
Facilities Per 1000 Pop, Age 65+	0.07 (US 0.10)

Home Health Care Agencies

Total Agencies	71
Agencies Per 1000 Pop, Age 65+	0.07 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.63 (US 3.6)
Expenditures Per 1000 Pop, 1992	$31,045 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	CON Only
Home Health Care Agencies	CON Only
Day Care Agencies	CON Only

NEW JERSEY

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. Rates and cost limits were rebased annually. The method employed a peer grouping by type of ownership (Governmental/Non Governmental). The basic reimbursement method was adopted in 1978. A facility fiscal year was used to set annual rates with 70% of the facilities beginning in January. Cost Reports were used to set rates of the 12 month period beginning six months after the end of each facility's Fiscal Year." Rates were trended using inflation, based on the CPI and average hourly earnings of factory workers published by NJ Dept. of Labor, severity, and case-mix. A minimum occupancy standard was set at 95% for property capital and property operating.

Adjustments

The rate period had a semi-annual adjustment of the nursing component for case-mix.

Cost Centers

Five rate components were used for setting rates. The rate components were: 1. Raw Foods, limited to 120% of median; 2. General Service: a. Assistant Administrator (limited to 125% for 99+ beds), b. Administration (limited by imputed formula), c. Other General Service (limited to 105% of the median); 3. Property-Operating: a. Tax (140% of County Median by land size), b. Utilities (limited to 150% of statewide median); 4. Patient Care (case-mix): a. Nursing (limited to 115% of minimum licensed staffing hours by median Salary levels), Special Patient Services, b. Medical Director (110% of median) c. Patient Activities (150% of median), d. Phar Consult (110% of median) e. Non-Legend Drugs (limited to 110% of median), f. Medical Supplies (limited to 150% of median), g. Social Services (limited to 110% of median), and h. Oxygen (limited to 110% of median); and 5. Property-Capital (including Return on Investment): a. Maintenance and replacement (110%) of median, b. Property Insurance (110% of median), and c. Appraised value (land limited to 110% of median construction cost in 1977 inflated forward for new construction).

Ancillary Services

Physical Therapy, Occupational Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Oxygen were included.

Case-Mix Adjusters

Case-mix was implemented October 1990. "Incidence of patents with seven specific types of conditions (Acuities)" were used in case-mix. Rates were set at an overall-facility basis and was case-mix was adjusted.

Capital Costs

The value of capital was determined by an Appraisal system. A square foot value limit was placed on the appraised value based upon year of construction. A size limit was placed on 360 square foot per bed. Capital-interest expenses were not directly valued. An appraisal based Capital Facilities Allowance (CFA) amount covers all property capital expenses (depreciation, interest, rental) and a return on equity if costs were less than CFA.

Reimbursement Rate

The 1993 average rate was $91.61, weighted by patient days, excluding specialty care and county facilities.

Other Long-Term Care

New Jersey has similar methods for hospital-based and free-standing nursing facilities. ICF-MR rates are retrospective but average about the same as in nursing facilities. Home health

Home health uses Medicare principles. Adult day care and sub-acute care methods are prospective facility-specific.

NEW JERSEY

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$91.61
Percentage Rate Change From Previous Year	3.09%
Peer Groupings	By Type of Ownership
Year of Cost Report to Set Rate	1992 (70% of facilities)
Inflation Adjustment	CPI and NJ Dept. of Labor Market Basket
Minimum Occupancy in Rate-Setting	95%
Case-Mix Adjusters	Acuity Measure, Entire Rate was Adjusted
Capital Reimbursement Determination	Appraisal
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$91.61
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Physician Services, Oxygen

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Facility-Specific
Program	NJ State Program
Average Rate	
By Facility Type	
Social	$25.00/Day
Day Health	$42.70/Day
By Client	
AIDS/ARC	$63.00/Day (under a waiver)
Pediatric	$86.00/Day

Sub-Acute Care

Method	Prospective Facility-Specific
Average Rate: AIDS/ARC	$275.00/Day

NEW MEXICO

Nursing Homes

The number of nursing homes in New Mexico increased from 38 in 1978 to 81 in 1993, although it had reached a high of 88 in 1988-1989. The number of beds more than doubled, growing from 2,910 in 1978 to 6,845 in 1993. The total bed growth rate for this period is 135.2, the second highest growth rate in the country.

Intermediate Care for Mentally Retarded

New Mexico had 35 ICF/MR facilities with 838 ICF/MR beds in 1993, an increase of 2 facilities and 6 beds since 1992. The ratio of ICF/MR beds per 1000 population was .52 in 1993, almost equalling the national ratio.

Other Residential Care

New Mexico licenses several different categories of residential care - family care, boarding homes, halfway homes, residential treatment homes, adult residential sheltered homes, and community residences for developmentally disabled adults. The first five categories vary by level of independence and medical need of residents. In 1993 there were 216 total facilities with 2,614 total beds.

Adult Day Care and Home Health Care

New Mexico had 12 licensed adult day care facilities in 1993. There were 88 licensed home care agencies in 1993, 77 of which were certified.

CON/Moratorium

New Mexico had a CON for nursing homes from 1978 through 1983, dropped it in 1984 and had neither a CON nor moratorium through 1993. In 1993 there was neither a CON nor moratorium on hospital bed conversion, residential care, or home health care. There was a moratorium on ICF/MRs. New Mexico has not had a CON or moratorium on home health care since at least 1978.

NEW MEXICO

Demographics

Percentage Population 65 and Over	11 % (US 12.7%)
Percentage Population 85 and Over	1.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	81
Total Beds	6845
Beds Per Nursing Home	84.5
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	38.5 (US 53.0)
Age 85 and Over	388.7 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.14 (US 6.2)
Expenditures Per 1000 Pop, 1992	$57,823 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	35
Total Beds	838
Beds Per Facility	23.9
Beds Per 1000 Population	0.52 (US 0.53)

Other Residential Care For Aged

Total Facilities	216[1]
Total Beds	2614[1]
Beds Per Facility	12.1
Beds Per 1000 Pop, Age 65+	14.72 (US 19.6)

Adult Day Care For Aged

Total Facilities	12
Facilities Per 1000 Pop, Age 65+	0.07 (US 0.10)

Home Health Care Agencies

Total Agencies	88
Agencies Per 1000 Pop, Age 65+	0.5 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.67 (US 3.6)
Expenditures Per 1000 Pop, 1992	$2,514 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	No CON nor Moratorium
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

NEW MEXICO

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping for type of ownership (State/Non State). The basic reimbursement method was adopted in 1984. A state fiscal year was used to set rates annually. The 1992 Cost report was used for 1993. New Mexico was on a three year rebasing cycle (July 1991) with the rate inflated in the other two years and prorated for lag time. Inflation based on the HCFA market basket was used to trend rates. Minimum occupancy was set at 90%.

Adjustments

Adjustments to the rate were made to those facilities requesting and receiving rebasing.

Cost Centers

There were two cost centers: 1. Operating, limited to 110% of median; and 2. Capital, which has a ceiling that grows yearly.

Ancillary Services

Physical Therapy, Occupational Therapy, Non-Prescription Drugs, Medical Supplies, Patient Transportation, and Nutritional supplements were included in the rate under routine Operating.

Case-Mix Adjusters

No case-mix adjusters were used in New Mexico. There were two levels of care: High and Low.

Capital Costs

The value of capital was determined by historic cost. The Medicare System valued capital-interest expenses. Refinancing (interest and depreciation), Renovation, and Rental Costs and Leases were allowed as costs. Depreciation charges were allowed. Straight Line was used for depreciation. The American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for New Mexico was $64.72, calculated by number of facilities.

Other Long-Term Care

New Mexico uses the same system for hospital-based as for free-standing nursing facilities. It has no Medicaid coverage of other residential care for the aged nor for adult day care, and has no separate program under Medicaid for sub-acute care.

NEW MEXICO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$64.72
Percentage Rate Change From Previous Year	-12.35%
Peer Groupings	Type of Ownership (state/non-state)
Year of Cost Report to Set Rate	1993
Inflation Adjustment	HCFA Market Basket Indicator
Minimum Occupancy in Rate-Setting	90% (new facilities or if beds were added)
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Non-Prescription Drug	Medical Supplies
Patient Transportation	Nutritional Supplements

Hospital-Based Nursing Facilities

Method — Same as Free-Standing Nursing Facilities

ICF-MR

Not Available

Home Health

Not Available

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

NEW YORK

Nursing Homes

The number of nursing homes in New York grew by ten facilities each year between 1978 and 1981. The growth had slowed to between 3 to 6 facilities a year for a total of 632 facilities in 1992, but then increased again to a total of 646 in 1993. The number of beds has been steadily increasing, growing from 90,178 in 1978 to 110,180 in 1993 - the third largest number of beds in the country but a ratio of beds per 1000 population aged 65 and over that was less than the national average (46.1 compared to 53.0).

Intermediate Care for Mentally Retarded

There were 1,158 ICF/MR facilities with 17,383 beds in New York in 1993, the largest number of ICF/MR facilities and beds in the country but a drop of 485 beds since 1992. New York is attempting to close all its large developmental centers by the year 2000 but still has a ratio of ICF/MR beds per 1000 population that is almost twice the national ratio (.96 compared to .53).

Other Residential Care

New York licenses 6 categories of residential care - not for profit adult homes, adult residences, adult homes, family type adult homes, enriched housing programs, and public homes. There were 1,284 facilities with 35,218 beds in 1993, an average of 27.4 beds per facility - about 11 beds higher than the national average.

Adult Day Care and Home Health Care

There are three categories of adult day care in New York - social day care provided in adult residences, medical day care operated as a service in nursing homes, and mental health day care or continuing day treatment. There were 98 social and medical day care facilities in 1993 and 14,989 "slots" in the mental health day care failities. The number of licensed home care agencies in New York has been growing rapidly, increasing from 236 in 1989 to 814 in 1993.

CON/Moratorium

New York had a CON for nursing homes from 1978 through 1993, with a moratorium added to it in 1986 (dropped in 1987). In 1993 the CON also covered hospital bed conversion, residential care, and home health care. It did not cover ICF/MRs. The CON on home health care has been in effect since 1978.

NEW YORK

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.6 % (US 1.4%)

Nursing Home Facilities

Total Facilities	646
Total Beds	110180
Beds Per Nursing Home	170.6
Average Occupancy Rate	99
Beds Per 1000 Population:	
Age 65 and Over	46.1 (US 53.0)
Age 85 and Over	387.3 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.42 (US 6.2)
Expenditures Per 1000 Pop, 1992	$200937 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	1158
Total Beds	17383
Beds Per Facility	15
Beds Per 1000 Population	0.96 (US 0.53)

Other Residential Care For Aged

Total Facilities	1284
Total Beds	35218
Beds Per Facility	27.4
Beds Per 1000 Pop, Age 65+	14.75 (US 19.6)

Adult Day Care For Aged

Total Facilities	98
Facilities Per 1000 Pop, Age 65+	0.04 (US 0.10)

Home Health Care Agencies

Total Agencies	814
Agencies Per 1000 Pop, Age 65+	0.34 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.66 (US 3.6)
Expenditures Per 1000 Pop, 1992	$112912 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	CON Only
Home Health Care Agencies	CON Only
Day Care Agencies	CON Only

NEW YORK

Free-Standing Nursing Facilities

Methods

A prospective facility-specific method was used for setting Medicaid reimbursement for nursing facility care. Peer groupings were used for geographic location, type of ownership, and number of beds. The basic method was adopted January 1, 1986, based on a calendar year for case-mix adjustments. The 1983 cost report was used for FY1993. Inflation based on the CWPI, a New York market basket, and a case-mix were used to trend rates. The minimum occupancy standard was 90%.

Adjustments

Quarterly adjustments to the initial rates can be made upward/downward and during/after the rate period, based on case mix. Appeals and Litigation can change the rate. Rates can be adjusted downward after the rate period with changes in patient acuity, appeals, and audits.

Cost Centers

A total of 44 cost centers were used including: 1. nursing, limited to 10% below and 5% above the statewide mean; 2. dietary, limited to 7.5% below and 5% above the mean; 3. housekeeping; 4. room and board; 5. other care-related direct, limited to 10% below and 5% above the mean; 6. Administration, limited to 7.5% below and 5% above the mean; 7. capital investment/rent (actual rentals only); and 8. equipment including lease hold improvements.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Prescription Drugs, Medical Supplies, Durable Medical Equip, Patient Transportation, Physician Services, Speech, Hearing, Dental, Podiatry, psychiatric, radiology, lab, electrocardiolgy, and electroencephalogy were included in the rate. Some were subject to a ceiling on direct costs.

Case-Mix Adjusters

Case-mix was adopted in 1986 using RUGs II factors. Case-mix was set on an overall facility basis, including direct and other patient care.

Capital Costs

The value of capital was determined by historic cost and appraisal/reappraisal and actual interest expense. Refinancing (interest and depreciation), refurbishing, and rental costs and leases were allowed as costs, but limited to the owner's cost. Depreciation charges were allowed with straight line and accelerated cost recovery. A sinking fund was required. A return on net equity called a "Real Property Equity" was allowed.

Reimbursement Rate

The 1993 reimbursement rate was $131.65, weighted by days of care. Operating plus ancillaries was 90% of the rate, the other 10% was for Capital.

Other Long-Term Care

New York did not provide data on hospital-based nursing facilities, ICF-MR, home health, other residential care for the aged, or adult day care.

It does not have a separate Medicaid sub-acute program.

NEW YORK

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$131.65
Percentage Rate Change From Previous Year	7.12%
Peer Groupings	Type of Ownership and Number of Beds
Year of Cost Report to Set Rate	1983
Inflation Adjustment	CWPI NY Market Basket & Case Mix
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	RUGS II; Direct Nursing & Other Patient Adjusted
Capital Reimbursement Determination	Historic Cost and Appraisal
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Prescription Drug	Medical Supplies
Durable Med. Equip.	Patient Transport
Physician Services	Electrocardiology
Electroencephalogy	Speech Therapy
Hearing	Dental Consult
Podiatry	Psychiatry
Radiology	Lab

Hospital-Based Nursing Facilities

Not Available

ICF-MR

Not Available

Home Health

Not Available

Other Residential Care For Aged

Not Available

Adult Day Care

Not Available

Sub-Acute Care

No Separate Program

NORTH CAROLINA

Nursing Homes

The number of nursing homes in North Carolina has been growing steadily, from 199 in 1978 to 393 in 1993. The number of beds has similarly been increasing, growing from 17,424 in 1978 to 37,801 in 1993. The ratio of beds per 1000 population aged 65 and over was less than the national ratio in 1993 (43.7 compared to 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in North Carolina increased from 260 in 1990 to 305 in 1993. There were 5,224 beds in 1993, an increase of 312 since 1992. The average number of beds per facility in 1993 was 17.1, about 5 beds less than the national average.

Other Residential Care

North Carolina licenses its residential care by size - family care homes have 6 residents or less, homes for the aged have 7 or more residents. There were 1,204 total facilities with 25,784 beds in 1993. The bed per facility ratio in 1993 was 21.4, about 5 beds higher than the national ratio.

Adult Day Care and Home Health Care

The number of adult day care facilities in North Carolina increased from 70 in 1989 to 80 in 1990, dropped to 71 in 1992, and then increased to 74 in 1993. In 1993 North Carolina had 650 licensed home care agencies, 219 of them certified.

CON/Moratorium

North Carolina had a CON for nursing homes between 1979 and 1993. A moratorium was added between 1981 and 1983. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. There were 55 CON applications for nursing homes in 1993, 32 of which were denied.

NORTH CAROLINA

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.2 % (US 1.4%)

Nursing Home Facilities

Total Facilities	393
Total Beds	37801
Beds Per Nursing Home	96.2
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	43.7 (US 53.0)
Age 85 and Over	453.8 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.01 (US 6.2)
Expenditures Per 1000 Pop, 1992	$69,580 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	305
Total Beds	5224
Beds Per Facility	17.1
Beds Per 1000 Population	0.75 (US 0.53)

Other Residential Care For Aged

Total Facilities	1204
Total Beds	25784
Beds Per Facility	21.4
Beds Per 1000 Pop, Age 65+	29.8 (US 19.6)

Adult Day Care For Aged

Total Facilities	74
Facilities Per 1000 Pop, Age 65+	0.09 (US 0.10)

Home Health Care Agencies

Total Agencies	650
Agencies Per 1000 Pop, Age 65+	0.75 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.45 (US 3.6)
Expenditures Per 1000 Pop, 1992	$18,837 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

NORTH CAROLINA

Free-Standing Nursing Facilities

Methods

A Combination method was used for setting Medicaid reimbursement for nursing facility care, was based on a facility-specific rate. The Direct portion (Nursing, dietary, house keeping, social services, patient activities, laundry/linen, and ancillaries) of the rate was set retrospectively, while the Indirect was set prospectively using a flat rate that was inflated forward. The method employed no peer groupings. The basic reimbursement method was adopted in 1977. A state fiscal year is used to set annual rates beginning October 1. The 1991 Cost report was used for 1993. Inflation based on a North Carolina market basket. No minimum occupancy standard was used for reimbursement.

Adjustments

Some adjustments were made but no specific information was available.

Cost Centers

Two cost centers are used for setting reimbursement rates in North Carolina: 1. Direct, limited to 80th percentile; and 2. Indirect.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Oxygen were included in the rate. Ancillary Services were included in the Direct cost center.

Case-Mix Adjusters

No case-mix adjusters were used in North Carolina. Two levels of were provided. There was also a composite rate for Enhanced Care (Ventilator and Head Injury).

Capital Costs

The value of capital was determined by historic cost. Appraisals were used to set rates. For capital-interest expenses, nursing facilities used Actual Interest Expense. Refinancing, renovation, and Rental Costs and Leases were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation. A return on net equity was provided for profit facilities. The lower of the Medicare rate or 11.875% was the maximum rate of return allowed. There is a cap on beds of $21,000.

Reimbursement Rate

The 1993 average reimbursement rate for North Carolina was $76.68 weighted by days of care.

Other Long-Term Care

North Carolina uses the same system for hospital-based as for free-standing nursing facilities, and a prospective facility-specific method for ICF-MR, with average ICF-MR rates over twice the average nursing facility rates.

Home health is reimbursed at charges up to a maximum rate, which is nearly double ($76.60) for a RN visit as for a home health aide visit ($42.75).

NORTH CAROLINA

Free-Standing Nursing Facilities

Method	Combination Facility-Specific, Adjusted
Average Reimbursement Rate	Not Available
Percentage Rate Change From Previous Year	Not Available
Peer Groupings	None
Year of Cost Report to Set Rate	1991
Inflation Adjustment	CPI & Market Basket
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusted	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies
Durable Med. Equip.	Patient Transport
Non-Prescription Drug	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Flat Rate
Private Facilities	Prospective Facility-Specific
Average Reimbursement Rate	
State Facilities	$184.00
Private Facilities	$178.50
Ancillary Services Included in Rate	
State Facilities	Includes All Ancillary Services
Private Facilities	Same as Free-Standing Nursing Facilities
Capital Reimbursement Determination (all facilities)	Historic Cost

Home Health

Method	Prospective on Industry Basis (max or change)
Average Reimbursement Rate, RN Visit	$76.60 (max rate)
Average Reimbursement Rate, HH Aide Visit	$42.75

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

NORTH DAKOTA

Nursing Homes

The number of nursing homes in North Dakota grew from 87 in 1978 to 97 in 1983 and remained fairly constant until 1989, when the number began to decrease. There were 84 facilities in 1993. The growth in beds had been slow but constant, increasing from 5,956 in 1978 to 7,084 in 1992, but then dropped slightly in 1993 to 7,071. The ratio of beds per 1000 population aged 65 and over was 75.2 in 1993, substantially greater than the U.S. average of 53.0.

Intermediate Care for Mentally Retarded

North Dakota had 62 ICF/MR facilities between 1989 and 1992, then dropped to 61 in 1993. The number of ICF/MR beds has been slowly decreasing, from 837 in 1989 to 773 in 1993. The ratio of beds per 1000 population was 1.22 in 1993, one of the highest ratios in the country.

Other Residential Care

North Dakota had 92 residential care facilities with 1,365 beds in 1993, including basic care facilities and adult foster care. There was an average of 14.8 beds per facility - about 2 beds less than the national average.

Adult Day Care and Home Health Care

North Dakota had 8 licensed adult day care facilities in 1993. There were 36 licensed home health care agencies in 1993, an increase of 2 from 1992. All but 2 of those agencies were certified.

CON/Moratorium

North Dakota had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, residential care, and home health care. There were 6 CON applications for nursing homes in 1993, none of which were denied.

NORTH DAKOTA

Demographics

Percentage Population 65 and Over	15 % (US 12.7%)
Percentage Population 85 and Over	2.0 % (US 1.4%)

Nursing Home Facilities

Total Facilities	84
Total Beds	7071
Beds Per Nursing Home	84.2
Average Occupancy Rate	97
Beds Per 1000 Population:	
Age 65 and Over	75.2 (US 53.0)
Age 85 and Over	560.5 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.87 (US 6.2)
Expenditures Per 1000 Pop, 1992	$135658 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	61
Total Beds	773
Beds Per Facility	12.7
Beds Per 1000 Population	1.22 (US 0.53)

Other Residential Care For Aged

Total Facilities	92
Total Beds	1365
Beds Per Facility	14.8
Beds Per 1000 Pop, Age 65+	14.52 (US 19.6)

Adult Day Care For Aged

Total Facilities	8
Facilities Per 1000 Pop, Age 65+	0.09 (US 0.10)

Home Health Care Agencies

Total Agencies	36
Agencies Per 1000 Pop, Age 65+	0.38 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.02 (US 3.6)
Expenditures Per 1000 Pop, 1992	$39,027 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	CON Only
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

NORTH DAKOTA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on both a patient specific and facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted January 1, 1990. A calendar year was used to set annual rates. The June 1992 Cost report was used for 1993. Inflation based on the DRI was used to trend rates. No minimum occupancy standard was used for setting rates.

Adjustments

Adjustments to the initial rates were made upward during the rate period and downward and during and after the rate period for all facilities. Adjustments were made at audit. No information was available on how often the facility rate changes were made.

Cost Centers

Four cost centers are used for setting reimbursement rates in North Dakota: 1. Nursing and Therapies (Direct), limited to 90% of 1988 costs trended forward; 2. Direct Other, limited to 90% of 1988 costs trended forward; 3. Property, passed through interest and depreciation; 4. Indirect, limited to 75% of 1988 costs trended forward.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Oxygen, and Patient Transportation were included in the rate.

Case-Mix Adjusters

Case-mix was adopted in 1990. North Dakota uses its own form of RUGs II to do their case-mix. Rates for case-mix reimbursement are set on an individual basis. Only the Direct Nursing care is accounted for in the case-mix. Sixteen levels of care were provided.

Capital Costs

The value of capital is determined by historic cost. For capital-interest expenses, nursing facilities used actual interest expense. Renovation was an allowable cost. The state allowed for depreciation charges. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for North Dakota was $74.29, weighted by days of care. The capital portion of the rate was $6.50.

Other Long-Term Care

North Dakota uses the same system for hospital-based as for free-standing nursing facilities, and a retrospective method to set ICF-MR rates, which average about two-thirds higher than do nursing facility rates. Home health services are paid under Medicare principles with state alterations, with a maximum rate of $60 for both RN and home health aide visits.

NORTH DAKOTA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$74.29
Percentage Rate Change From Previous Year	3.2%
Peer Groupings	None
Year of Cost Report to Set Rate	June 1992
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	RUGS III; Direct Nursing Care Adjusted.
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies
Non-Prescription Drug	Patient Transport
Durable Med. Equip.	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$129.90
Minimum Occupancy in Rate-Setting	95% (may be waived in settlement process)
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Patient Transport
Non-Prescription Drug	Medical Supplies
Oxygen	

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$60.00 (maximum)
Average Reimbursement Rate, HH Aide Visit	$60.00

Other Residential Care For Aged

None

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program

OHIO

Nursing Homes

The number of nursing homes in Ohio grew from 969 in 1990 to 988 in 1993, the third most nursing homes in the country. The number of beds increased from 90,529 to 90,860 during this period. The ratio of beds per 1000 population aged 65 and over in 1993 was above the national average (61.4 compared to 53.0).

Intermediate Care for Mentally Retarded

In 1993 Ohio began licensing and counting its ICF/MR cottages separately rather than as single units. There were 367 ICF/MR facilities with 6,882 beds that year. The average number of beds per facility in 1993 was 18.8, about 3 beds less than the national average.

Other Residential Care

Ohio had 864 residential care facilities with 11,744 beds in 1993. There was an average of 13.6 beds per facility that year, about 3 beds less than the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Ohio. Home care is not licensed but there were 304 certified home care agencies in 1993. Bills are pending this year to license both adult day care and home health care.

CON/Moratorium

Ohio had a CON for nursing homes from 1978 through 1993, with a moratorium added in 1983 (dropped in 1984), 1987 (dropped in 1988), and 1993. In 1993 the CON/moratorium also covered hospital bed conversion, while there was neither a CON nor moratorium on ICF/MRs, residential care, or home health care. There were 24 CON applications for nursing homes in 1993, 5 of which were denied.

OHIO

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	988
Total Beds	90860
Beds Per Nursing Home	92
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	61.4 (US 53.0)
Age 85 and Over	586.2 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.36 (US 6.2)
Expenditures Per 1000 Pop, 1992	$124291 (US $92,314)
Adequacy of Bed Supply	Under Supply

Intermediate Care For Mentally Retarded

Total Facilities	367
Total Beds	6882
Beds Per Facility	18.8
Beds Per 1000 Population	0.62 (US 0.53)

Other Residential Care For Aged

Total Facilities	864
Total Beds	11744
Beds Per Facility	13.6
Beds Per 1000 Pop, Age 65+	7.93 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.25 (US 3.6)
Expenditures Per 1000 Pop, 1992	$6,430 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

OHIO

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1980. In 1990 Ohio added case-mix but put it in limbo mandated by the governor, with special procedures for a two year interim period. Case-mix will be reinstated in July 1993. A state fiscal year was used to set rates in six month report periods beginning July 1 of 1991. The Cost reports from the last six months of 1991 were used for 1993. Inflation based on the CPI was used to trend rates. Occupancy was imputed by actual days for Direct care and 85% of total bed days for Administration and General. A minimum occupancy standard was set at 80% for new facilities during their first six months of operation.

Adjustments

Retroactive upward adjustments were made one time due to an interim rate adjustment from settlement at audit.

Cost Centers

Cost centers were not used to set the rate in 1993.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Patient Transportation, were included in the rate. Included in the rate under total cost.

Case-Mix Adjusters

Ohio dropped case-mix in 1991 for a temporary two year period, after which case-mix will come back on line. Implementation was set for July 1993, incorporating RUGs III into the new system. Two levels of care were provided.

Capital Costs

The value of capital was determined by historic cost. For capital interest expenses, nursing facilities used the actual interest expense, subject to a ceiling. Refinancing, Renovation, and Rental Costs and Leases were allowable costs. The straight line method and The American Hospital Guidelines were used for depreciation. A return on net equity was paid to For profit nursing homes only.

Reimbursement Rate

The 1993 flat reimbursement rate for Ohio was $84.63, the statue specified rate.

Other Long-Term Care

Ohio uses the same system for hospital-based as for free-standing nursing facilities, and retrospective payment for ICF-MRS, which average over twice the per diem rate for free-standing nursing facilities. Home health care is paid under a fee schedule with flat rates, twice as high ($41.41) for a RN as for a home health aide visit ($20.71). Adult day care is covered under waiver, using a prospective class method. Sub-acute care is paid under contracted prospective facility-specific rates.

OHIO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$84.63
Percentage Rate Change From Previous Year	0.00%
Peer Groupings	None
Year of Cost Report to Set Rate	1991
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	80% New Facilities (first six months)
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	

Hospital-Based Nursing Facilities

Method: Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Retrospective Class
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	
State Facilities	$208.37
Private Facilities	Not Available
Ancillary Services Included in Rate	
State Facilities	Included All Ancillary Services
Private Facilities	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$41.41
Average Reimbursement Rate, HH Aide Visit	$20.71

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Class
Program	1915c Waiver
Facility Types	Social and Day Health
Average Rate: Aged	$33.64

Sub-Acute Care

Method	Prospective Facility-Specific (contract negotiated)
Average Rate: Pediatric	$230.00 - $330.00

OKLAHOMA

Nursing Homes

The number of nursing homes in Oklahoma grew slowly between 1978 and 1985, increasing from 369 to 377 facilities. The growth rate accelerated to a total of 422 in 1992, but the number of facilities then dropped to 415 in 1993. The growth in beds had been constant, increasing from 26,270 beds in 1978 to 34,581 beds in 1992, but dropped slightly in 1993 to 34,457. The 1993 ratio of beds per 1000 population aged 65 was 78.3, well above the national average.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has remained fairly constant in Oklahoma, increasing from 23 facilities in 1989 to 29 facilities in 1993. The number of beds grew from 2,056 in 1989 to 3,132 in 1993. The ratio of beds per 1000 population in 1993 was almost double the national ratio.

Other Residential Care

Oklahoma had 102 licensed residential care homes with a total of 3,058 beds in 1993. There was an average of 30.0 beds per facility that year, almost 2 times the national average.

Adult Day Care and Home Health Care

Oklahoma had 14 licensed adult day care facilities in 1993, a drop of 3 since 1992. Home care is not licensed in Oklahoma (licensure has been approved but regulations are still pending) but there were 153 certified home care agencies in 1993.

CON/Moratorium

Oklahoma had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion and ICF/MRs. It did not cover residential care or home health care. There were 44 CON applications for nursing homes in 1993, 3 of which were denied.

OKLAHOMA

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.6 % (US 1.4%)

Nursing Home Facilities

Total Facilities	415
Total Beds	34457
Beds Per Nursing Home	83
Average Occupancy Rate	83.3
Beds Per 1000 Population:	
Age 65 and Over	78.3 (US 53.0)
Age 85 and Over	664.9 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	7.77 (US 6.2)
Expenditures Per 1000 Pop, 1992	$70,391 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	29
Total Beds	3132
Beds Per Facility	108
Beds Per 1000 Population	0.97 (US 0.53)

Other Residential Care For Aged

Total Facilities	102
Total Beds	3058
Beds Per Facility	30
Beds Per 1000 Pop, Age 65+	6.95 (US 19.6)

Adult Day Care For Aged

Total Facilities	14
Facilities Per 1000 Pop, Age 65+	0.03 (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.73 (US 3.6)
Expenditures Per 1000 Pop, 1992	$16,910 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

OKLAHOMA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a flat rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1978. A state fiscal year was used to set annual rates beginning July 1. The 1990 Cost report was used for 1993 Inflation based on the DRI was used to trend rates. No minimum occupancy standard was used to set rates.

Adjustments

No upward adjustment. A single downward adjustment during the rate period was made due to legislative budget constraint.

Cost Centers

Three cost centers were used: 1. Operating, an overall general limit, limited by the weighted mean; 2. Administrative Service, limited to $2.10 per patient day; and Capital, limited to $5.43 per patient day.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Physician Services were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Oklahoma. One level of care was provided. Implementation of a Case-mix system is set for 1995.

Capital Costs

The value of capital was determined by historic cost. A flat allowance of $5.43 for capital was paid. Depreciation charges were included if they fell within the allowance. For capital interest expenses, nursing facilities actual interest expense, subject to a ceiling. Refinancing, Renovation, and Rental Costs and Leases were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation. A Rental Factor of $5.43 (same as capital allowance) was paid.

Reimbursement Rate

The 1993 flat reimbursement rate for Oklahoma was $48.90. Operating costs were $41.08, Ancillaries were $2.39, and Capital was $5.43.

Other Long-Term Care

Oklahoma uses the same system for hospital-based as for free-standing nursing facilities. It also uses the same method for private ICF-MRs, which are paid about 25% more than nursing facilities, and the same method, but with retrospective adjustments, for state ICF-MRs, which have rates over five-times that for nursing facility care. Home health is reimbursed using Medicare principles, paying over five times the average rate for a RN visit ($85) as for a home health aide visit ($15).

OKLAHOMA

Free-Standing Nursing Facilities

Method	Prospective Class
Average Reimbursement Rate	$48.90
Percentage Rate Change From Previous Year	5.38%
Peer Groupings	None
Year of Cost Report to Set Rate	1990
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Physician Services
Occupational Therapy	Respiratory Therapy
Non-Prescription Drug	Medical Supplies
Patient Transport	Oxygen

Hospital-Based Nursing Facilities

Method: Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Class (retroactive adjustments)
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	
State Facilities	$278.30
Private Facilities	$58.00
Ancillary Services Included in Rate	

All Facilities:	Physical Therapy	Physicians Services
	Occupational Therapy	Non-Prescription Drug
	Medical Supplies	Patient Transport
	Durable Medical Equip	
State Facilities Only:	Respiratory Therapy	
Private Facilities Only:	Speech Therapy	Music Audiology
	Recreation Therapy	Habilitative Service
	Lab	X-Ray
	Dental Consult	Psychology

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$85.00
Average Reimbursement Rate, HH Aide Visit	$15.00

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

OREGON

Nursing Homes

The number of nursing homes in Oregon has been steadily decreasing, from 200 in 1978 to 177 in 1992 and 1993. The number of beds increased from 14,653 in 1978 to 14,811 in 1993. The bed growth rate between 1978 and 1993 was 1.08, the smallest positive growth rate in the country.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Oregon dropped from 8 in 1990 to 6 1992 to 2 in 1993. The number of beds dropped from 991 to 546 during this period. The ratio of ICF/MR beds per 1000 population in 1993 was .18, substantially lower than the national ratio of .53.

Other Residential Care

Oregon licenses 3 categories of residential care - adult foster care with fewer than 5 beds, and residential care and assisted living with greater than 5 beds. There were 2,297 facilities with 14,061 beds in 1993.

Adult Day Care and Home Health Care

Adult day care is not licensed in Oregon. There were 83 licensed home care agencies, 79 of them certified, in 1993.

CON/Moratorium

Oregon had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion and ICF/MRs. It did not cover other residential care or home health care. There were 4 CON applications for nursing homes in 1993, none of which were denied.

OREGON

Demographics

Percentage Population 65 and Over	14 % (US 12.7%)
Percentage Population 85 and Over	1.5 % (US 1.4%)

Nursing Home Facilities

Total Facilities	177
Total Beds	14811
Beds Per Nursing Home	83.7
Average Occupancy Rate	82.7
Beds Per 1000 Population:	
Age 65 and Over	35.4 (US 53.0)
Age 85 and Over	328.1 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.96 (US 6.2)
Expenditures Per 1000 Pop, 1992	$49,141 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	2
Total Beds	546
Beds Per Facility	273
Beds Per 1000 Population	0.18 (US 0.53)

Other Residential Care For Aged

Total Facilities	2297
Total Beds	14061
Beds Per Facility	6.1
Beds Per 1000 Pop, Age 65+	33.63 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	83
Agencies Per 1000 Pop, Age 65+	0.2 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.41 (US 3.6)
Expenditures Per 1000 Pop, 1992	$40,710 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

OREGON

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. This method was previously classified as combination with a prospective portion in Indirect Care, while the Direct care was retrospectively set. However, Interim rates were set for the Direct Care cost center, so this component is now classified as Prospective adjusted. The method employed no peer groupings. The basic reimbursement method was adopted in 1986. A state fiscal year was used to set annual rates beginning July 1. The September 1990 cost reports were used for the Indirect portion of the, while the September 1991 cost reports were used for the Direct portion. Inflation based on the DRI was used to trend rates for the Direct portion of the rate and the CPI was used for the Indirect portion of the rate. A minimum occupancy standard was not used to set rates. A minimum occupancy standard of 95% was used in the Fair Rental System.

Adjustments

Adjustments to the initial rates were made upward during the rate period one to twelve time due to the interim rate adjustment. Adjustment were made downward during the rate period once or twice due to the interim rate adjustment. The percent of facilities was unknown.

Cost Centers

Two cost centers were used for setting reimbursement rates in Oregon: 1. Indirect, limited by a flat rate; and 2. Direct, limited to the 80th percentile of a state wide mean.

Ancillary Services

Physical Therapy (if PT is on staff), Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Patient Transportation, and Oxygen (part) were included in the Direct portion of the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Oregon. Five levels of care were provided.

Capital Costs

The value of capital was determined by a modified system using Historic cost and Rental Value. For capital interest expenses, nursing facilities used the, actual interest expense. Renovation and Rental Costs and Leases were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation

Reimbursement Rate

The 1993 average reimbursement rate for Oregon was $69.55, weighted by patient days Operating Cost combined with Ancillaries was $56.27, Ancillary Services were $3.89 and Capital was $9.39.

Other Long-Term Care

Oregon uses the same system for hospital-based as for free-standing nursing facilities, and a retrospective method to set ICF-MR rates, which average well over four times as much as nursing facility rates. Home health visits are paid using a fee-schedule with a flat $53 rate for both RN and home health aide visits. Other residential care for the aged is paid under waivers using differing methods: and adult day care is covered under waivers, using retrospective methods.

OREGON

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$69.55
Percentage Rate Change From Previous Year	3.24%
Peer Groupings	None
Year of Cost Report to Set Rate	Sept. 1990 (indirect) or Sept. 1991(direct)
Inflation Adjustments	DRI
Minimum Occupancy in Rate-Setting	95% (fair rental system)
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost and Rental Value
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Patient Transport
Oxygen	

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$320.51
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities plus Prescription Drug, Physician Services, and Durable Med. Equip.

Home Health

Method	Fee-Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$53.00/Visit
Average Reimbursement Rate, HH Aide Visit	$53.00/Visit

Other Residential Care For Aged

Method	Retrospective Facility-Specific/Class
Program	1915c & 1915d Waivers
Average Rate by Service	
Foster Home (Adult)	$500.00/Month
Residential Care	$400.00/Month
Assisted Living	$1000.00/Month

Adult Day Care

Method	Retrospective Contract Negotiation
Program	1915d & 1915c Waivers
Average Rate: Day Health	$20.00/Day
Clients Covered	Aged

Sub-Acute Care

No Separate Program

PENNSYLVANIA

Nursing Homes

The number of nursing homes in Pennsylvania fluctuated slightly between 1978 and 1993 but showed an overall increase from 633 facilities to 730 facilities during that period. The number of beds has been steadily increasing, growing from 66,673 in 1978 to 92,529 in 1993. The ratio of beds per 1000 population aged 65 and over was 48.5 in 1993, less than the national average.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Pennsylvania has been growing rapidly, increasing from 161 to 252 between 1989 and 1993. The number of beds grew during this period from 7,761 to 8,333. The bed per facility ratio in Pennsylvania in 1993 was 33.1, about 11 beds greater than the national average.

Other Residential Care

There were 1,422 personal care homes with 46,520 beds in Pennsylvania in 1993, the third highest number of residential care beds in the country. There was an average of 32.7 beds per facility that year, about twice the national average.

Adult Day Care and Home Health Care

There were 420 licensed adult day care facilities in Pennsylvania in 1993, the second most in the country. There were 334 licensed home care agencies, 281 of them certified, in 1993.

CON/Moratorium

Pennsylvania had a CON for nursing homes from 1979 through 1993. In 1993 the CON covered hospital bed conversion and ICF/MRs. It did not cover residential care or home health care. There were 9 CON applications for nursing homes in 1993, none of which were denied.

PENNSYLVANIA

Demographics

Percentage Population 65 and Over	16 % (US 12.7%)
Percentage Population 85 and Over	1.6 % (US 1.4%)

Nursing Home Facilities

Total Facilities	730
Total Beds	92529
Beds Per Nursing Home	126.8
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	48.5 (US 53.0)
Age 85 and Over	468.6 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.82 (US 6.2)
Expenditures Per 1000 Pop, 1992	$104013 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	252
Total Beds	8333
Beds Per Facility	33.1
Beds Per 1000 Population	0.69 (US 0.53)

Other Residential Care For Aged

Total Facilities	1422
Total Beds	46520
Beds Per Facility	32.7
Beds Per 1000 Pop, Age 65+	24.39 (US 19.6)

Adult Day Care For Aged

Total Facilities	420
Facilities Per 1000 Pop, Age 65+	0.22 (US 0.10)

Home Health Care Agencies

Total Agencies	334
Agencies Per 1000 Pop, Age 65+	0.18 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.45 (US 3.6)
Expenditures Per 1000 Pop, 1992	$1,699 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

PENNSYLVANIA

Free-Standing Nursing Facilities

Methods

A retrospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1976 or 1978. A state fiscal year was used to set annual rates beginning July 1. Interim rates and ceilings were upgraded annually. The 1991 Cost report from January or July was used for 1993. Inflation based on the CPI and a market basket indicator were used to trend rates. The minimum occupancy standard was set at 90%.

Adjustments

Adjustments to the initial rates were made upward one to two times for all facilities due to an interim rate followed by adjustment based on cost reports.

Cost Centers

Twenty four cost centers were used for setting reimbursement rates in Pennsylvania. The only individual limit was a staffing limitation. A comprehensive limit was defined by geographic area.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, and Physician Services, were in the rate if allowed under salaried/contract. Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Oxygen, and Patient Transportation were also included in the rate. Ancillaries were part of net operating cost.

Case-Mix Adjusters

No case-mix adjusters were used in Pennsylvania. Case-mix will be implemented in the future. Three levels of care are provided.

Capital Costs

The value of capital was determined by historic cost. For capital interest expenses, nursing facilities used the actual interest expense. Refinancing, Renovation, and Rental Costs and Leases were allowable costs. A cap not to exceed the prime rate limits allowable interest rates. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average rate for Pennsylvania was $73.82.

Other Long-Term Care

Pennsylvania uses the same system for hospital-based as for free-standing nursing facilities, but with a separate ceiling, resulting in rates over twice as high as for free-standing nursing facilities. Private ICF-MRs are paid using a retrospective method with allowable costs, state ICF-MRs under a retrospective method with full costs but some limits. Home health services are paid using a fee schedule with a flat rate over twice as high ($51) for RN visits as for home health aide visits ($24).

PENNSYLVANIA

Free-Standing Nursing Facilities

Method	Retrospective
Average Reimbursement Rate	$73.82
Percentage Rate Change From Previous Year	8.50%
Peer Groupings	None
Year of Cost Report to Set Rate	1991
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	90%
Ancillary Services Included in Rate	
	Non-Prescription Drug, Medical Supplies, Physical Therapy, Occupational Therapy, Respiratory Therapy, Durable Med. Equip., Physician Services, Patient Transport, Oxygen
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities (separate ceiling)
Average Reimbursement Rate	$161.17 (skilled)

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific (full cost/some limits)
Private Facilities	Retrospective Facility-Specific (allowable cost)
Average Reimbursement Rate (private facilities)	$179.38
Ancillary Services Included in Rate (all facilities)	Physical Therapy, Occupational Therapy, Non-Prescription Drug, Physician Services, Patient Transport, Speech/Hearing, Psychology/Counseling
Capital Reimbursement Determination	Historic Cost (all facilities) and Rental Value (private facilities)

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$51.00
Average Reimbursement Rate, HH Aide Visit	$24.00

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

None

Sub-Acute Care

No Separate Program

RHODE ISLAND

Nursing Homes

The number of nursing homes in Rhode Island remained fairly constant between 1978 and 1986, decreasing from 112 to 110 during that period. The rate of decline had been somewhat faster after that - in 1992 there were 103 facilities - but in 1993 the number increased to 105. The number of beds has been steadily increasing, from 8,228 in 1978 to 10,222 in 1992 to 10,463 in 1993. The ratio of beds per 1000 population age 65 and over was 67.7 in 1993, greater than the national ratio of 53.0.

Intermediate Care for Mentally Retarded

Between 1991 and 1992 41 facilities that had been "certified" by the Division of Facilities Regulation went "waiver"- they are still licensed by the Office of Mental Retardation but are no longer certified by Dept. of Facilities Regulation due to their meeting much less stringent criteria (basically custodial care with no accreditation). The remaining facilities are still certified by Facilities Regulation. In 1993 there were 69 certified ICF/MR facilities with 620 certified beds.

Other Residential Care

Residential care grew in Rhode Island from 29 facilities in 1989 to 43 facilities in 1993, the second fewest facilities in the country. There were 1,130 residential care beds in 1993, up from 557 in 1989.

Adult Day Care and Home Health Care

Rhode Island had 13 licensed adult day care facilities between 1989 and 1992 but added a 14th in 1993. There were 17 licensed home care agencies in 1993, up from 15 in 1992.

CON/Moratorium

Rhode Island had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion and home health care. It did not cover ICF/MRs or residential care. There were 4 CON applications for nursing homes in 1993, only 1 of which was denied.

RHODE ISLAND

Demographics

Percentage Population 65 and Over	16 % (US 12.7%)
Percentage Population 85 and Over	1.7 % (US 1.4%)

Nursing Home Facilities

Total Facilities	105
Total Beds	10463
Beds Per Nursing Home	99.6
Average Occupancy Rate	96.31
Beds Per 1000 Population:	
Age 65 and Over	67.7 (US 53.0)
Age 85 and Over	603 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	26.77 (US 6.2)
Expenditures Per 1000 Pop, 1992	$184739 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	69
Total Beds	620
Beds Per Facility	9
Beds Per 1000 Population	0.62 (US 0.53)

Other Residential Care For Aged

Total Facilities	43
Total Beds	1130
Beds Per Facility	26.3
Beds Per 1000 Pop, Age 65+	7.31 (US 19.6)

Adult Day Care For Aged

Total Facilities	14
Facilities Per 1000 Pop, Age 65+	0.09 (US 0.10)

Home Health Care Agencies

Total Agencies	17
Agencies Per 1000 Pop, Age 65+	0.11 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	15.99 (US 3.6)
Expenditures Per 1000 Pop, 1992	$60,500 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

RHODE ISLAND

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. No peer groupings were used. The basic reimbursement method was adopted in 1978. A calendar year was used to set annual rates annually beginning January 1. The earliest cost report used was FY1990 for FY1993. Inflation based on the NNHIPI was used to trend rates. The minimum occupancy standard was set at 88%.

Adjustments

No adjustments were made to the initial rate.

Cost Centers

Seven cost centers were used for setting reimbursement rates in Rhode Island: 1. Fixed Property Expenses, limited to 100th percentile of median; 2. Other Property Related Expenses, limited to 80th percentile; 3. Labor and Payroll Related Expenses, limited to 90th percentile; 4. Energy Expenses, limited to 90th percentile; and 5. All Other Expenses, limited to 80th percentile with $18.97 ceiling for new construction; 6. Management Expense, limited to the 75th percentile; 7. OBRA-87 Expenses, limited to 100th percentile (Assessment reimbursed at cost).

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Durable Medical Equipment, Physician Services, Laundry, and Patient Transportation were included in the rate. Ancillary Services are included in the rate based on cost report calculations.

Case-Mix Adjusters

Case-mix adjusters were used in Rhode Island beginning in 1990. A mix of patient measures were used: RUGs, ADLs, Indicator of patient mental status, and an Acuity measurement. Rate were set based on overall facility basis. The entire rate was case-mix adjusted.

Capital Costs

The value of capital was determined by a combination of Replacement Costs, Market Value, and Rental Value. For capital interest expense, nursing facilities used the actual interest expense. Refinancing, Renovation, and Rental Costs and Leases were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation. A return on equity was provided. The rental factor was based on a gross rental system. It was applied to an appreciating property base and based on a real rate of return.

Reimbursement Rate

The average reimbursement rate for 1993 was 85.76.

Other Long-Term Care

Rhode Island uses the same system for hospital-based as for free-standing nursing facilities, and a similar system for ICF-MRs, which average almost three times the per diem rate of nursing facilities. Home health care is paid using Medicare principles with state alterations. Other residential care for the aged is covered under waiver, using a prospective facility-specific method. Adult day care is covered under waiver, using a prospective flat rate method.

RHODE ISLAND

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$85.76
Percentage Rate Change From Previous Year	-22.66%
Peer Groupings	Not Available
Year of Cost Report to Set Rate	1990
Inflation Adjustment	NNHI Price Index
Minimum Occupancy in Rate-Setting	88%
Case-Mix Adjusters	Variety of Measurements Entire Rate was CM Adjusted
Capital Reimbursement Determination	Replacement Cost, Market Value, & Rental Value
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Physician Services
Medical Supplies	Durable Med. Equip.
Patient Transport	Laundry

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Facility-Specific (differs from free-standing facilities)
Average Reimbursement Rate	$245.00
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Patient Transport

Home Health

Method	Medicare Principles with State Alterations

Other Residential Care For Aged

Method	Prospective Facility-Specific
Program	2176 Waiver
Rate by Facility Type	Not Available

Adult Day Care

Method	Prospective Flat Rate
Program	2176 Waiver
Average Rate	$16.70/Day
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care

No Separate Program

SOUTH CAROLINA

Nursing Homes

The number of nursing homes in South Carolina has been steadily increasing, growing from 109 in 1978 to 174 in 1993. The number of beds increased from 9,875 in 1978 to 12,899 in 1983, decreased to 12,389 in 1986, and has been increasing since then to a total of 16,211 in 1993. The ratio of beds per 1000 population aged 65 and over in 1993 was 38.0, well below the national ratio.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in South Carolina grew from 119 in 1990 to 153 in 1993, while the number of beds decreased slightly from 3,443 to 3,418. The 1993 ratio of beds per 1000 population was .94, almost double the national average.

Other Residential Care

South Carolina had 439 community residential care facilities in 1993, an increase of 49 from 1990. The number of beds grew from 6,670 to 9,217 during that period. The average number of beds per facility in South Carolina in 1993 was 21.0, about 5 beds above the national average.

Adult Day Care and Home Health Care

There were 36 licensed adult day care facilities in South Carolina in 1993. There were 70 licensed home care agencies, up from 62 in 1992.

CON/Moratorium

South Carolina had a CON for nursing homes from 1978 through 1993, with a moratorium added to it between 1980 and 1988. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. There were 17 CON applications for nursing homes in 1993, none of which were denied.

SOUTH CAROLINA

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	174
Total Beds	16211
Beds Per Nursing Home	93.2
Average Occupancy Rate	94.2
Beds Per 1000 Population:	
Age 65 and Over	38 (US 53.0)
Age 85 and Over	422.4 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.78 (US 6.2)
Expenditures Per 1000 Pop, 1992	$55,849 (US $92,314)
Adequacy of Bed Supply	Under Supply

Intermediate Care For Mentally Retarded

Total Facilities	153
Total Beds	3418
Beds Per Facility	22.3
Beds Per 1000 Population	0.94 (US 0.53)

Other Residential Care For Aged

Total Facilities	439
Total Beds	9217
Beds Per Facility	21
Beds Per 1000 Pop, Age 65+	21.63 (US 19.6)

Adult Day Care For Aged

Total Facilities	36
Facilities Per 1000 Pop, Age 65+	0.08 (US 0.10)

Home Health Care Agencies

Total Agencies	70
Agencies Per 1000 Pop, Age 65+	0.16 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.73 (US 3.6)
Expenditures Per 1000 Pop, 1992	$8,604 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

SOUTH CAROLINA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed peer groupings by number of beds and type of ownership. The basic reimbursement method was adopted in 1986. The federal fiscal year was used to set annual rates. The September 1991 Cost report was used for 1993. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 98%.

Adjustments

Adjustments to the initial rates were made upward twice during the rate year for all facilities based on cost report information.

Cost Centers

Nine cost centers were used for setting reimbursement rates in South Carolina: 1. General Services, limited to 105% of mean; 2. Dietary, limited to 105% of mean; 3. Housekeeping, laundry, & Maintenance, limited to 105% of mean; 4. Administration, Medical Records & Services, limited to 105% of mean; 5. Utilities; 6. Medical Supplies; 7. Special Services; 8. Capital, Taxes, Insurance: Building and Equipment; and 9. Legal Fees.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, and Medical Supplies, were included in the rate.

Case-Mix Adjusters

Case-mix was adopted July 1986. Percent of Skilled ("Bands" or levels) by overall facility was taken into account in case-mix. General Services including Direct Nursing Care, Indirect Nursing Care and Other patient care were part the case-mix adjusted rate. Two levels of care were provided.

Capital Costs

The value of capital was determined by a combination of cost based and fair rental in a Modified System that uses the Market Value of a bed plus the mean rate of return. No capital-interest expense was paid. Renovation was an allowable cost. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for South Carolina was $64.99, weighted by days of care.

Other Long-Term Care

South Carolina uses the same system for hospital-based as for free-standing nursing facilities, and a prospective facility-specific method without adjustments for ICF-MRS, which are paid about two-thirds more than nursing facilities. Home health is reimbursed using Medicare principles with state alterations, paying over 50% more on average for a RN visit ($65) as for a home health aide visit ($35). Adult day care is covered under waiver using a prospective flat method.

SOUTH CAROLINA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$64.99
Percentage Rate Change From Previous Year	-0.38%
Peer Groupings	Number of Beds and Type of Ownership
Year of Cost Report to Set Rate	September 1991
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	98%
Case-Mix Adjusters	Acuity Measurement; Direct, Indirect, & Other Patient Adjusted
Capital Reimbursement Determination	Combination (see text page)
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies
Non-Prescription Drug	Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Facility-Specific
Average Reimbursement Rate	$103.82
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing minus Non-Prescription Drugs

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$55.00
Average Reimbursement Rate, HH Aide Visit	$35.00

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Flat Rate
Program	2176 Waiver
Facility Type	Day Health
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill
Reimbursement Rate	Not Available

Sub-Acute Care

No Separate Program

SOUTH DAKOTA

Nursing Homes

The number of nursing homes in South Dakota has remained constant, decreasing from 117 in 1978 to 115 in 1993. The number of beds has been slowly increasing, from 7,386 in 1978 to 8,256 in 1993. The ratio of beds per 1000 population aged 65 and over was 78.3 in 1993, well above the U.S. ratio of 53.0.

Intermediate Care for Mentally Retarded

There is no licensure of ICF/MRs in South Dakota. The Office of Developmental Disabilities "certifies" ICF/MRs and the state counts this as their licensure. The number of ICF/MR facilities in South Dakota decreased from 19 in 1989 to 16 in 1992 to 15 in 1993 while the number of beds dropped from 671 to 626 to 614. The ratio of ICF/MR beds per 1000 population was .86 in 1993, also well above the national average.

Other Residential Care

South Dakota licenses assisted living facilities and adult foster care. There were 108 total facilities with 625 beds in 1993 (not including unlicensed "residential living"), a drop of 22 facilities and 79 beds since 1992. There was an average of 5.8 beds per facility in 1993, the fourth smallest average in the country.

Adult Day Care and Home Health Care

The number of adult day care facilities in South Dakota has been slowly increasing, growing from 8 in 1989 to 13 in 1993. There were 19 licensed home care agencies between 1990 and 1992, but by 1993 there were 25.

CON/Moratorium

South Dakota had a CON for nursing homes from 1978 to 1987. In 1988 the state dropped the CON and instituted a moratorium, which has been in effect through 1993. In 1993 the moratorium also covered hospital bed conversion. It did not cover, nor was there a CON for, ICF/MRs, residential care, or home health care. There has not been a CON or moratorium on home health care since at least 1978.

SOUTH DAKOTA

Demographics

Percentage Population 65 and Over	15 % (US 12.7%)
Percentage Population 85 and Over	2.0 % (US 1.4%)

Nursing Home Facilities

Total Facilities	115
Total Beds	8256
Beds Per Nursing Home	71.8
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	78.3 (US 53.0)
Age 85 and Over	577.4 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.64 (US 6.2)
Expenditures Per 1000 Pop, 1992	$99,745 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	15
Total Beds	614
Beds Per Facility	40.9
Beds Per 1000 Population	0.86 (US 0.53)

Other Residential Care For Aged

Total Facilities	108
Total Beds	625
Beds Per Facility	5.8
Beds Per 1000 Pop, Age 65+	5.92 (US 19.6)

Adult Day Care For Aged

Total Facilities	13
Facilities Per 1000 Pop, Age 65+	0.12 (US 0.10)

Home Health Care Agencies

Total Agencies	25
Agencies Per 1000 Pop, Age 65+	0.24 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.84 (US 3.6)
Expenditures Per 1000 Pop, 1992	$26,105 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	Moratorium Only
Hospitial Bed Conversion	Moratorium Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

SOUTH DAKOTA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed a peer grouping of geographic location by Urban/Rural. The basic reimbursement method was adopted in 1975. A state fiscal year was used to set and rebase rates annually beginning July 1 of each year. The 1991 cost reports (Calendar Year) were used for 1993. Inflation based on the DRI was used to trend rates. The minimum occupancy standard was set at three percent less than the annual state-wide average or actual, whichever is higher.

Adjustments

No adjustments to the initial rate were made.

Cost Centers

Six cost centers were used for setting reimbursement rates: 1. Patient Care, limited to 110% of state-wide average for group classification; 2. Dietary, limited to 110% of state-wide average; 3. Administration, limited to 110% of state-wide average; 4. Laundry, limited to 110% of state-wide average; 5. Plant and Operational, subject to final ceiling of 110% of state wide average, per group classification, for all costs; and 6. Capital, subject to final ceiling of 110% of state wide average, per group classification, for all costs.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, Physician Services, and Oxygen were included in the rate. Ancillaries were included in the operating costs the same as other cost centers.

Case-Mix Adjusters

No case-mix adjusters were used in South Dakota. Implementation of case-mix is set for FY1994 (7/93).

Capital Costs

The value of capital was determined by historic cost. No revaluation was performed. For capital-interest expense, nursing facilities used the actual interest expense. Refinancing, Renovation, and Rental Costs and Leases were allowable costs (interest only). Depreciation charges were allowed. The straight line method and the American Hospital Guidelines were used for depreciation. The minimum depreciation period allowed is 33 years. A return on net equity was provided. The rate was 6.1%, subject to overall capital limitation.

Reimbursement Rate

The 1993 average reimbursement rate for South Dakota was $60.00, weighted by days of care.

Other Long-Term Care

South Dakota uses the same system for hospital-based as for free-standing nursing facilities, the same method for state ICF-MRs, and a combination method for private ICF-MRs.

Home health visits are paid using Medicare principles, with RN visits ($23.10) paid on average over twice the rate as are home health aide visits ($10.50).

SOUTH DAKOTA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$60.00
Percentage Rate Change From Previous Year	10.46%
Peer Groupings	Geographic Location by Rural/Urban
Year of Cost Report to Set Rate	1991 Calendar Year
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	3 % Less Than the State-Wide Average
Case-Mix Adjusters	Case-Mix Demonstration
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	Physician Services
Oxygen	

Hospital-Based Nursing Facilities

Method	Included in Free-Standing Nursing Facilities Rate

ICF-MR

Method	
State Facilities	Prospective Facility-Specific
Private Facilities	Combination Facility-Specific
Average Reimbursement Rate	Not Available

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$23.10
Average Reimbursement Rate, HH Aide Visit	$10.50

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

TENNESSEE

Nursing Homes

The number of nursing homes in Tennessee has been steadily increasing, growing from 209 in 1978 to 319 in 1993. The number of beds has been increasing as well, from 18,505 in 1978 to 36,708 in 1993. The ratio of beds per 1000 population aged 65 and over was 56.4 in 1993, just above the national ratio.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has been growing rapidly in Tennessee, increasing from 6 in 1989 to 50 in 1992 to 60 in 1993. The number of beds dropped from 2,810 in 1992 to 2,478 in 1993, however, due to the downsizing of several of the larger developmental centers.

Other Residential Care

Tennessee licenses two categories of residential care for the aged - institutional homes for the aged with greater than 50 beds, and residential care for the aged with fewer than 50 beds. In 1993 there was a total of 248 facilities with 6,743 beds.

Adult Day Care and Home Health Care

Adult day care is not licensed in Tennessee. The number of licensed home care agencies declined from 326 in 1989 to 303 in 1992 to 296 in 1993.

CON/Moratorium

Tennessee had a CON for nursing homes from 1978 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. There were 24 CON applications for nursing homes in 1993, 8 of which were denied.

TENNESEE

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.4 % (US 1.4%)

Nursing Home Facilities

Total Facilities	319
Total Beds	36708
Beds Per Nursing Home	115.1
Average Occupancy Rate	91.5
Beds Per 1000 Population:	
Age 65 and Over	56.4 (US 53.0)
Age 85 and Over	528.2 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.14 (US 6.2)
Expenditures Per 1000 Pop, 1992	$83,165 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	60
Total Beds	2478
Beds Per Facility	41.3
Beds Per 1000 Population	0.49 (US 0.53)

Other Residential Care For Aged

Total Facilities	248
Total Beds	6743
Beds Per Facility	27.2
Beds Per 1000 Pop, Age 65+	10.36 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	296
Agencies Per 1000 Pop, Age 65+	0.45 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.53 (US 3.6)
Expenditures Per 1000 Pop, 1992	$2,498 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

TENNESSEE

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted around 1978 with some modifications in 1990. A state fiscal year was used to set annual rates beginning July 1. The 1991[2] cost reports were used for FY1993. Inflation based on a Tennessee market basket was used to trend rates. A minimum occupancy standard was set at 80%, reduced by five percent for each five percent change down to a minimum of 60%.

Adjustments

Adjustments to the initial rates were made only for errors or audit adjustments.

Cost Centers

Cost centers were not used to determine rates in Tennessee. A comprehensive limit was set at the 65th percentile for all facilities.

Ancillary Services

Physical Therapy, Non-Prescription Drugs, and Medical Supplies, were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Tennessee. Two levels of care were provided.

Capital Costs

The value of capital was determined by historic cost. For capital-interest expense, nursing facilities used actual interest expense. Interest, lease fees, rent, and depreciation were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation. A return on net equity was provided to profit facilities of 6.5%. The average return on equity was limited to the Medicare allowable.

Reimbursement Rate

The 1993 average reimbursement rate for Tennessee was $68.99, calculated by number of facilities.

Other Long-Term Care

Tennessee uses the same system for hospital-based as for free-standing nursing facilities, and the same method for ICF-MR, which averages almost three-times the per diem rate as do nursing facilities. Home health is reimbursed using Medicare principles with state alterations, paying over twice the average rate for a RN visit ($69.26) as for a home health aide visit ($32.87).

[1] The ICF facilities were set prospectively, while the SNF facilities were set retrospective with an interim rate. The interim rate categorized the state as overall prospective.

[2] The most recently filed and reviewed cost report as of June 1 was used for rate determination in 1993.

TENNESSEE

Free-Standing Nursing Facilities

Method	Combination Facility-Specific
Average Reimbursement Rate	$68.99
Rate Increase, 1991-199	10.70%
Peer Groupings	None
Year of Cost Report to Set Rate	1991[1]
Inflation Adjustment	TN Market Basket
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusted	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy — Medical Supplies
Non-Prescription Drug

Hospital-Based Nursing Facilities

Method: Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$184.62
Ancillary Services Included in Rate	

Physical Therapy — Occupational Therapy
Respiratory Therapy — Non-Prescription Drug
Medical Supplies — Physician Services

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$69.26
Average Reimbursement Rate, HH Aide Visit	$32.87

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

[1] The most recently filed and reviewed cost report as of June 1 was used for rate determination in 1993.

TEXAS

Nursing Homes

The number of nursing homes in Texas has fluctuated slightly but has shown an overall increase from 973 facilities in 1978 to 1,242 facilities in 1993, the second largest number of facilities in the country. The number of beds has followed a similar pattern of fluctuation but has grown from 97,709 in 1978 to 122,843 in 1993, also the second largest number in the country. The ratio of beds per 1000 population aged 65 and over was 66.9 in 1993, greater than the U.S. ratio of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Texas more than doubled between 1989 and 1992, increasing from 318 facilities to 676 facilities, but in 1993 dropped back to 665 facilities - the second highest number of ICF/MR facilities in the country. The number of ICF/MR beds increased between 1989 and 1993 from 12,435 beds to 14,765 beds, the second highest number of ICF/MR beds in the country. The 1993 ratio of beds per 1000 population was .82, well above the national average.

Other Residential Care

Texas provides its residential care in personal care homes. There were 362 of these facilities with 10,807 beds in 1993, an increase of 66 facilities and 1,441 beds since 1992.

Adult Day Care and Home Health Care

The number of adult day care facilities in Texas more than doubled between 1989 and 1992, increasing from 49 facilities to 107 facilities. In 1993 there were 127. There were 1,214 licensed home care agencies in Texas in 1993, the second most in the country.

CON/Moratorium

Texas had a CON for nursing homes between 1978 and 1984. In 1985 the state dropped the CON and instituted a moratorium. In 1993 the moratorium also covered hospital bed conversion. It did not cover, nor was there a CON for, ICF/MRs, residential care, or home health care. There has not been a CON or moratorium on home health care since at least 1978.

TEXAS

Demographics

Percentage Population 65 and Over	10 % (US 12.7%)
Percentage Population 85 and Over	1.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	1242
Total Beds	122843
Beds Per Nursing Home	98.9
Average Occupancy Rate	82
Beds Per 1000 Population:	
Age 65 and Over	66.9 (US 53.0)
Age 85 and Over	635.1 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.06 (US 6.2)
Expenditures Per 1000 Pop, 1992	$54,281 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	665
Total Beds	14765
Beds Per Facility	22.2
Beds Per 1000 Population	0.82 (US 0.53)

Other Residential Care For Aged

Total Facilities	362
Total Beds	10807
Beds Per Facility	29.9
Beds Per 1000 Pop, Age 65+	5.89 (US 19.6)

Adult Day Care For Aged

Total Facilities	127
Facilities Per 1000 Pop, Age 65+	0.07 (US 0.10)

Home Health Care Agencies

Total Agencies	1214
Agencies Per 1000 Pop, Age 65+	0.66 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	3.49 (US 3.6)
Expenditures Per 1000 Pop, 1992	$10,262 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	Moratorium Only
Hospitial Bed Conversion	Moratorium Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

TEXAS

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on patient-specific[1] with a portion of the rate fixed. No peer groupings were used. The basic reimbursement method was adopted in 1989 when Texas added case-mix. A calendar year was used to set annual rates. The 1991 cost reports were used for 1993. Inflation based on the DRI and IPD-PCE, plus other indices per condition, were used to trend rates. The minimum occupancy standard was 81.842%.

Adjustments

No adjustments to the initial rates were made.

Cost Centers

Three cost centers were used for setting rates in Texas: 1. General, Administration, and Dietary (GAD), limited to costs of median facility; 2. Average Patient Care (APC); and 3. Fixed Capital Asset Use Fee (FCAUF), limited to lower of previous FCAUF or Imputed Alternative.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Patient Transportation, were averaged into the rate.

Case-Mix Adjusters

Case-mix was adopted April 1989. Texas used TILEs (Texas Index for Level of Effort) modeled after RUGs I. Rates were set on a mix of individual-patient and overall-facility. Only certain cost centers were case-mix adjusted. The GAD plus FCAUF added to the APC were adjusted by one of II TILEs. Direct Nursing Care, was accounted for in the case-mix rate. Eleven levels of care were provided.

Capital Costs

The value of capital was determined by Appraisal. Texas had a Fixed Capital Asset Use Fee. Two alternative methods existed for calculating the facility fee: The lower of the previous years fee, adjusted for inflation or an imputed fee capped at the 80th percentile adjusted by inflation and the minimum occupancy standard. Refinancing, renovation, and Rental Costs and Leases were allowable costs in the Use Fee. No cap was place on the allowable interest. A reappraisal was done for major capital investment. No depreciation charges were allowed.

Reimbursement Rate

The 1993 average reimbursement rate for Texas was $56.17. Operating costs totaled $51.11 and Capital was $5.06.

Other Long-Term Care

Texas uses the same system for hospital-based as for free-standing nursing facilities, and a prospective flat rate for ICF-MRs. Home health visits are paid under Medicare principles. There is no residential care or adult day health payment under Medicaid, and no separate Medicaid subacute program.

[1] Texas was self classified as based on a flat rate. Because of the nature of case-mix it was reclassified as facility-specific.

TEXAS

Free-Standing Nursing Facilities

Method	Prospective Patient-Specific
Average Reimbursement Rate	$56.17
Percentage Rate Change From Previous Year	3.05%
Peer Groupings	None
Year of Cost Report to Set Rate	1990
Inflation Adjustment	IPD-PCE and Other Indices Per Condition
Minimum Occupancy in Rate-Setting	85% of State-Wide Average
Case-Mix Adjusters	RUGS; Entire Rate was CM adjusted.
Capital Reimbursement Determination	Appraisal/Reappraisal
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Patient Transport	

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Flat Rate (weighted median)
Average Reimbursement Rate	Not Available
Capital Reimbursement Determination	Historic Cost

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

UTAH

Nursing Homes

The number of nursing homes in Utah has grown slightly, from 92 in 1978 to 100 in 1993. The number of beds has grown faster, from 5,758 in 1978 to 7,125 in 1993, but has been around 7,100 since 1990. In 1993 the ratio of beds per 1000 population aged 65 and over was 43.2, less than the national average 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Utah has remained constant, increasing only from 10 to 14 facilities between 1989 and 1993. The number of ICF/MR beds increased from 986 in 1989 to 1,003 in 1990 but decreased to 965 in 1993. The average number of beds per facility in 1993 was 68.9, about 3 times the national average.

Other Residential Care

Utah had 67 residential care facilities with 1,344 beds (not including 45 "slots" for adult foster care) in 1993, an increase of 9 facilities and 166 beds since 1992. There was an average of 20.1 beds per facility in 1993, almost 4 beds above the national average.

Adult Day Care and Home Health Care

There were 7 licensed adult day care facilities in Utah between 1990 and 1992. In 1993 that number dropped to 5. The number of licensed home care agencies increased from 46 in 1989 to 72 in 1993, 55 of which were certified.

CON/Moratorium

Utah had a CON for nursing homes from 1979 to 1984. It dropped the CON in 1985 and had not reinstated it through 1993. However, in 1993 Utah did institite a moratorium on nursing homes (it had one in 1989 as well). In 1993 the moratorium also covered ICF/MRs, while there was neither a CON nor moratorium on hospital bed conversion, residential care, or home health care. Utah did have a CON for home health care from 1980 to 1989 but dropped it in 1990.

UTAH

Demographics

Percentage Population 65 and Over	8.9 % (US 12.7%)
Percentage Population 85 and Over	0.9 % (US 1.4%)

Nursing Home Facilities

Total Facilities	100
Total Beds	7125
Beds Per Nursing Home	71.3
Average Occupancy Rate	82
Beds Per 1000 Population:	
Age 65 and Over	43.2 (US 53.0)
Age 85 and Over	438.2 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	0.82 (US 6.2)
Expenditures Per 1000 Pop, 1992	$6,968 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	14
Total Beds	965
Beds Per Facility	68.9
Beds Per 1000 Population	0.52 (US 0.53)

Other Residential Care For Aged

Total Facilities	67
Total Beds	1344
Beds Per Facility	20.1
Beds Per 1000 Pop, Age 65+	8.16 (US 19.6)

Adult Day Care For Aged

Total Facilities	5
Facilities Per 1000 Pop, Age 65+	0.03 (US 0.10)

Home Health Care Agencies

Total Agencies	72
Agencies Per 1000 Pop, Age 65+	0.44 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.16 (US 3.6)
Expenditures Per 1000 Pop, 1992	$16,286 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	Moratorium Only
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

UTAH

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a class rate by levels of care. The method employed no peer groupings. The basic reimbursement method was adopted in 1980. A state fiscal year was used to set annual rates beginning July 1. The 1990 Cost report was used for 1993. Inflation based on the UT market basket was used to trend rates. No minimum occupancy standard was set.

Adjustments

No adjustments to the initial rates were made.

Cost Centers

Eight cost centers were used for setting reimbursement rates in Utah: 1. Nursing, limited to 120% of median; 2. Dietary, limited to 60-70th percentile; 3. Housekeeping, limited to 50-55th percentile; 4. Administration; limited to 50-55th percentile; 5. Capital (property), limited to $6.85; 6. Plant Operation, limited to 50-55th percentile; 7. Laundry and Linen, limited to 50-55th percentile; and 8. Recreation and Social, limited to 50-55th percentile.

Ancillary Services

Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Patient Transportation, were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Utah. Four levels of care are provided according to the state.

Capital Costs

The value of capital was determined by historic cost limited to March 1981 cost. For capital-interest expenses, nursing facilities used the actual interest, subject to a ceiling. Depreciation applied to the 1981 cost report. The straight line method was used for depreciation with a maximum depreciation period of 35 years.

Reimbursement Rate

The 1993 average reimbursement rate for Utah was $67.53, weighted by days of care. Operating costs totaled $24.16, Ancillary Services combined with Nursing were $35.26 and Capital was $8.21.

Other Long-Term Care

Utah uses the same system for hospital-based as for free-standing nursing facilities, and Medicare principles for ICF-MRs. State ICF-MRs average rates nearly three-times those for nursing facilities, while private ICF-MR rates are on average less than 50% higher than those for nursing facilities. Home health is paid according to a fee schedule with flat rates, paying over twice the average rate for a RN visit ($72) as for a home health aide visit ($34). Other residential care for the aged is covered under waiver, using patient-specific contract negotiation. Adult day care is covered using prospective facility-specific methods, sub-acute care using prospective patient-specific methodology.

UTAH

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$67.53
Percentage Rate Change From Previous Year	0.52%
Peer Groupings	None
Adjustments to Prospective Rate	None
Year of Cost Report to Set Rate	1990
Inflation Adjustment	UTAH Market Basket
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusted	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Respiratory Therapy, Medical Supplies, Durable Med. Equip., Non-Prescription Drug, Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$59.68

ICF-MR

Method	
State Facilities	Retrospective Medicare Principles
Private Facilities	Retrospective Flat Rate
Average Reimbursement Rate	
State Facilities	$195.00
Private Facilities	$94.23
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Durable Med. Equip., Non-Prescription Drug, Patient Transport

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$72.00
Average Reimbursement Rate, HH Aide Visit	$34.00

Other Residential Care For Aged

Method	Patient-Specific & Contract Negotiation
Program	1115c Wavier
Average Rate By Facility Type	
Group Home	$30-$100/Day

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	Not Available
Average Rate: Social	$25.00/Day
Clients Covered	Aged

Sub-Acute Care

Method	Prospective Patient-Specific
Average Rate: Pediatric Ventilator Care	$380.00/Day

VERMONT

Nursing Homes

The number of nursing homes has remained constant in Vermont, increasing from 48 facilities in 1978 to 51 facilities in 1992 and then decreasing to 50 in 1993. The number of beds has been slowly increasing, from 2,852 in 1978 to 3,645 in 1993. The 1993 ratio of beds per 1000 population aged 65 and over, 52.6, just about equalled the national ratio.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Vermont dropped from 12 to 9 between 1989 and 1993. The number of ICF/MR beds dropped with the facility drop from 266 in 1989 to 178 in 1992 to 54 in 1993, when the state's largest ICF/MR closed. The 1993 ratio of beds per 1000 population was .09, substantially less than the national ratio of .53. The average number of beds per facility in Vermont in 1993 was 6.0, the second lowest average in the country.

Other Residential Care

There are two categories of residential care in Vermont - level IV no nursing overview and level III nursing overview. In 1993 there was a total of 185 facilities with 2,200 beds, an average of 11.9 beds per facility - about 5 beds less than the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Vermont. Home care is not licensed but in 1993 there were 13 certified agencies.

CON/Moratorium

Vermont had a CON for nursing homes from 1979 through 1993. In 1993 the CON also covered hospital bed conversion, ICF/MRs, and home health care. It did not cover residential care. There was 1 CON application submitted and approved for a nursing home in 1993.

VERMONT

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.5 % (US 1.4%)

Nursing Home Facilities

Total Facilities	50
Total Beds	3645
Beds Per Nursing Home	72.9
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	52.6 (US 53.0)
Age 85 and Over	427 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.41 (US 6.2)
Expenditures Per 1000 Pop, 1992	$102635 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	9
Total Beds	54
Beds Per Facility	6
Beds Per 1000 Population	0.09 (US 0.53)

Other Residential Care For Aged

Total Facilities	185
Total Beds	2200
Beds Per Facility	11.9
Beds Per 1000 Pop, Age 65+	31.75 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	6.52 (US 3.6)
Expenditures Per 1000 Pop, 1992	$46,150 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	CON Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

VERMONT

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care in, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1983. A state fiscal year was used to set annual rates beginning July 1. The earliest cost report used for FY93 was FY1993. Inflation based on DRI was used to trend rates. The minimum occupancy standard was set at 90% except for facilities with twenty or fewer beds.

Adjustments

Quarterly adjustments were made to the rates.

Cost Centers

Costs were separated into ten categories: 1. Nursing, limited to 140% of the median; 2. Resident Care, limited to 125% of median; 3. Indirect Care, limited to 115% of the Median; 4. Ancillary, 5. Director of Nursing, 6. Property, 7. OBRA, 8. Return on Equity, 9. Efficiency Incentives and 10. Special Adjustments

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Speech Therapy, Inhalation Therapy, and Oxygen, were included in the rate. Ancillaries were a separate rate component.

Case-Mix Adjusters

Case-mix was adopted January 1, 1992. In July 1992 Vermont developed a special score which narrowly defined 29 classes, then in October 1992 a one time add-on was included for Workers Compensation Insurance. RUG's III factors, plus a behavioral component, were used in their case-mix system. Case-mix reimbursement was set on and overall-facility basis. The Direct Nursing Care category was the case-mix portion of the rate. Two levels of care were provided.

Capital Costs

The value of Capital was determined by the Historic cost. For capital-interest expense, nursing facilities used actual interest expense. Refinancing (interest only); Renovation; and Rental Costs and Leases (not for related party) were allowable costs. The straight line method and the American Hospital Guidelines were used for depreciation. Proprietary facilities receive an adjustment for net equity of $ .53.

Reimbursement Rate

The 1993 average reimbursement rate for Vermont was approximately $84.19 (excluding specialty facilities), weighted by days of care. Operating costs totaled $76.22, Ancillary Services were $1.22 and Capital was $6.75.

Other Long-Term Care

Vermont uses the same system for hospital-based as for free-standing nursing facilities, but retrospective methods for ICF-MR, with an average rate nearly three-times as high as for nursing facilities. Home health rates are set by a fee schedule with flat rates, on a per-visit basis for RN services ($59) but by the quarter-hour for home health aide services ($5.25). Adult day care is covered under waiver, using a retrospective reimbursement method.

VERMONT

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific Adjusted
Average Reimbursement Rate	$84.19
Percentage Rate Change From Previous Year	4.4%
Peer Groupings	None
Year of Cost Report to Set Rate	1993
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	90% (20 or fewer beds can be waivered)
Case-Mix Adjusted	RUGS III, Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies
Non-Prescription Drug	Durable Med. Equip.
Patient Transport	Speech Therapy
Inhalation Therapy	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$224.23
Ancillary Services Included in the Rate	Same as Free-Standing Nursing Facilities plus Physician Services

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$59.00
Average Reimbursement Rate, HH Aide Visit	$5.25/Quarter Hour

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Retrospective Flat Rate
Program	2176 Waiver
Facility Type	Social and Dementia/Alzheimer's Disease
Average Rate by Client	$26.35

Sub-Acute Care

None

VIRGINIA

Nursing Homes

The number of nursing homes in Virginia has been steadily increasing, growing from 163 in 1978 to 282 in 1993. The number of beds has been steadily increasing as well, growing from 16,283 in 1978 to 30,738 in 1993. The ratio of beds per 1000 population aged 65 and over was 43.2 in 1993, less than the U.S. ratio of 53.0.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has grown from 9 in 1989 to 16 in 1993. The number of beds increased from 105 to 154 during this period. The 1993 ratio of ICF/MR beds per 1000 population was .02, the lowest ratio in the country.

Other Residential Care

The number of residential care facilities in Virginia has been steadily increasing, from 471 in 1989 to 650 in 1993. The number of beds increased from 27,515 to 33,040 during this period (these numbers include both adult care residences and homes for the aged affiliated with nursing homes). The average number of beds per facility in 1993 was 50.8, the third highest average in the country.

Adult Day Care and Home Health Care

Virginia had 44 licensed adult day care facilities and 62 licensed home care agencies in 1993. All home health agencies in Virginia must initially be licensed. They can then opt to become certified and either keep or drop licensure. Most drop licensure because of its stringent requirements. In 1993 there were 181 certified home health agencies.

CON/Moratorium

Virginia had a CON for nursing homes from 1978 through 1993, adding a moratorium to it in 1987 that remained in effect through 1993. In 1993 the CON/moratorium also covered hospital bed conversion, while a CON alone covered ICF/MRs. There was neither a CON nor moratorium for residential care or home health care. There were 8 CON applications for nursing homes in 1993, only 1 of which was denied.

VIRGINIA

Demographics

Percentage Population 65 and Over	11 % (US 12.7%)
Percentage Population 85 and Over	1.1 % (US 1.4%)

Nursing Home Facilities

Total Facilities	282[1]
Total Beds	30738[1]
Beds Per Nursing Home	109
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	43.2 (US 53.0)
Age 85 and Over	435.9 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.14 (US 6.2)
Expenditures Per 1000 Pop, 1992	$52,249 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	16[1]
Total Beds	154[1]
Beds Per Facility	9.6
Beds Per 1000 Population	0.02 (US 0.53)

Other Residential Care For Aged

Total Facilities	650
Total Beds	33040
Beds Per Facility	50.8
Beds Per 1000 Pop, Age 65+	46.42 (US 19.6)

Adult Day Care For Aged

Total Facilities	44
Facilities Per 1000 Pop, Age 65+	0.06 (US 0.10)

Home Health Care Agencies

Total Agencies	62
Agencies Per 1000 Pop, Age 65+	0.09 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.65 (US 3.6)
Expenditures Per 1000 Pop, 1992	$9,516 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

[1] **Estimate**

VIRGINIA

Free-Standing Nursing Facilities

Methods

A Combination of methods was used for setting Medicaid reimbursement for nursing facility care in the state of Virginia. The retrospective portion of the rate was for Capital, while the prospective was for Operating, both Direct and Indirect. This method was based on a facility-specific rate. The method employs a peer grouping for Geographic Location by Metro/Rest of State. The basic reimbursement method was adopted in 1990. A facility fiscal year was used to set annual rates. The earliest cost reports used for 1993 were year facility year ending 1991. Inflation based on the DRI was used to trend rates. The minimum occupancy standard was set at 95% for Plant and Operation.

Adjustments

Adjusted. The state sets semi-annual rates for the Operating portion, therefore it was adjusted during a fiscal year.

Cost Centers

Three cost centers were used for setting reimbursement rates in Virginia: 1. Direct; 2. Indirect; and 3. Plant (Capital).

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, and Non-Prescription Drugs, were included in the rate.

Case-Mix Adjusters

Case-mix was adopted 1991. Case-mix was based on a resource-based measure or Patient Intensity Rating System (PIRS). Only the Direct portion of the rate was case-mixed. Three levels of care were provided.

Capital Costs

The value of capital was determined by Historic cost. For capital interest expense, nursing facilities used the Medicare System. Refinancing, Renovation, and Rental Costs and Leases were allowable costs. Allowable interest was limited to the prevailing interest rate. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 (year ending 1992) average reimbursement rate for Virginia was $63.57, weighted by days of care.

Other Long-Term Care

Virginia has the same system for hospital-based and free-standing nursing facilities. A retrospective method with caps for ICF-MR average rates almost three-times nursing facility rates. Home health uses a fee schedule with ranges much higher for RN than for home health aide visits. Adult day care is waivered, using a prospective flat method. Sub-acute care also has prospective flat rates.

VIRGINIA

Free-Standing Nursing Facilities

Method	Combination Facility-Specific, Adjusted
Average Reimbursement Rate	$65.50
Percentage Rate Change From Previous Year	3.04%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1991
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	95% (except for first year facilities)
Case-Mix Adjusted	Resource-Based Measure, Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Non-Prescription Drug

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific (capped)
Average Reimbursement Rate	$173.26
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$61.08-$168.56 Range
Average Reimbursement Rate, HH Aide Visit	$36.24-$51.64 Range

Other Residential Care For Aged

None

Adult Day Care

Method	Prospective Flat Rate
Program	2176 Waiver
Facility Type	Social
Average Rate	$28.00/Day (6 hours)
Clients Covered	Aged

Sub-Acute Care

Method	Prospective Flat
Average Rate	
AIDS / HIV	$211.75
Ventilation	$282.75
Comprehensive Rehabilitation	$344.50
Complex Health Care	$334.50

WASHINGTON

Nursing Homes

The number of nursing homes in Washington has fluctuated but has shown an overall decrease from 310 facilities in 1978 to 298 facilities in 1992 to 289 in 1993. The number of beds has also fluctuated but showed a slow increase from 28,225 in 1978 to 29,241 in 1992 before dropping to 28,703 in 1993. The total annual growth rate in number of beds for this period is 1.69, one of the smallest growth rates in the country.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Washington grew between 1989 and 1992, increasing from 6 to 16 facilities during that period before dropping to 15 in 1993. The number of ICF/MR beds decreased from 1,907 to 1,720 between 1989 and 1993. The ratio of beds per 1000 population was .33 in 1993, substantially less than the national average of .53.

Other Residential Care

There are two categories of residential care in Washington (not including board and care for the mentally retarded) - adult family homes and licensed boarding homes. There were 1,443 total facilities with 17,739 beds in 1993, up from 1,172 facilities and 16,021 beds in 1989. There was an average of 12.3 beds per facility in 1993, about 4 beds less than the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Washington. The number of licensed home care agencies has been growing rapidly, increasing from 75 in 1989 to 142 in 1992 to 156 in 1993.

CON/Moratorium

Washington had a CON for nursing homes from 1978 through 1992, adding a moratorium to it in 1993. In 1993 the CON/moratorium also covered hospital bed conversion, while a CON alone covered home health care. There was neither a CON nor moratorium on ICF/MRs or residential care in 1993. There were 7 CON applications for nursing homes in 1993, none of which were denied.

WASHINGTON

Demographics

Percentage Population 65 and Over	12 % (US 12.7%)
Percentage Population 85 and Over	1.2 % (US 1.4%)

Nursing Home Facilities

Total Facilities	289
Total Beds	28703
Beds Per Nursing Home	99.3
Average Occupancy Rate	90
Beds Per 1000 Population:	
Age 65 and Over	46.9 (US 53.0)
Age 85 and Over	449.1 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.01 (US 6.2)
Expenditures Per 1000 Pop, 1992	$74,791 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	15
Total Beds	1720
Beds Per Facility	114.7
Beds Per 1000 Population	0.33 (US 0.53)

Other Residential Care For Aged

Total Facilities	1443
Total Beds	17739
Beds Per Facility	12.3
Beds Per 1000 Pop, Age 65+	29 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	156
Agencies Per 1000 Pop, Age 65+	0.25 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	0.87 (US 3.6)
Expenditures Per 1000 Pop, 1992	$1,260 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

WASHINGTON

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement[1] for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of Geographic location by MSA Region. The basic reimbursement method was adopted in 1980. The 1991 calendar year cost report was the basis for state fiscal year 1993 rates. Inflation based on the MCCPI. The minimum occupancy standard was set at 85%.

Adjustments

Adjustments to the initial rates were made upward during the rate period one time for seventy percent of the facilities due to appeal. Adjustments upward retroactively were made one time for ten percent of the facilities due to litigation. Adjustments downward during the rate period were made one time for ten percent of the facilities due to appeal.

Cost Centers

Five cost centers were used for setting reimbursement rates in Washington: 1. Nursing Services, growth limited to MCCPI for inflation; 2. Administration and Operation (All Other), limited to 85th percentile; 3. Food (raw); 4. Property; and 5 Financing (Return on Investment). Administration and Operation (All Other) was considered a general limit on operating costs.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Patient Transportation, were included in the rate. Ancillary cost were attributable only to Medicaid recipients.

Case-Mix Adjusters

No case-mix adjusters were used in Washington. They do have an Exceptional care level that affects few facilities or days of care.

Capital Costs

The value of capital was determined by a historic cost or appraisal. The historic cost was primarily used, next appraisals, and then the market value. Capital-interest expenses were not paid. Renovation was an allowable cost. The straight line method and the American Hospital Guidelines were used for depreciation. Washington employed a Return on Investment based on net equity. The rate of return allowed was 10% of net.

Reimbursement Rate

The 1993 average reimbursement rate for Washington was $85.60, weighted by days of care. The Operating component was $67.60, Ancillary Services were, $9.00 and Capital was $9.00.

Other Long-Term Care

Washington has the same system for hospital-based and free-standing nursing facilities, and contracted rates for ICF-MR that average twice as high for private and over three-times as high for state ICF-MRs as for nursing facilities. Home health rates are set by a fee schedule with flat rates by geographic area, with RN rates twice as high ($80.58) as home health aide rates ($43.63). Residential care uses prospective class methods. Adult day care uses prospective facility-specific methods.

[1] Washington state defines rates as payment rather than reimbursement.

WASHINGTON

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$85.60
Percentage Rate Change From Previous Year	-1.07%
Peer Groupings	Geographic Location by MSA Region
Year of Cost Report to Set Rate	1991
Inflation Adjustment	MCCPI
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost or Appraisal
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State	June 1992
Private	Contracted Facilities Similar to Free-Standing Facilities
Average Reimbursement Rate	
State Facilities	$272.00
Private Facilities	$185.00
Capital Reimbursement Determination (all facilities)	Historic Cost

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$80.58[1]
Average Reimbursement Rate, HH Aide Visit	$43.63[1]

Other Residential Care For Aged

Method	Prospective Class
Program	Under State Plan and/or 1915c Waiver
Facility Type	Group, Family, Foster Homes, and Residential Care
Flat Rate	$26.58/Day

Adult Day Care

Method	Prospective Facility-Specific
Program	Under State Plan (rehabilitation services)
Average Rate by Facility Type	
Day Health	$41.64/Day
AIDS	$23.00/Day
Clients Covered	Aged; Physically & Deveopmentally Disabled; Mentally Ill; Substance Abuse; AIDS/HIV; and Pediatric

Sub-Acute Care

No Separate Program

[1] Regional Area averages divided by ten areas.

WEST VIRGINIA

Nursing Homes

The number of nursing homes in West Virginia has been steadily increasing, growing from 79 in 1978 to 127 in 1993. The number of beds has been rapidly increasing, from 5,451 in 1978 to 10,797 in 1993, but the ratio of beds per 1000 population aged 65 and over was still less than the national average (38.9 compared to 53.0).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities grew from 46 in 1989 to 64 in 1992 before dropping to 62 in 1993. The number of ICF/MR beds grew from 574 to 714 in 1992 before dropping to 709 in 1993. The bed per facility ratio in West Virginia was 11.4 in 1993, about 10 beds less than the national average.

Other Residential Care

There were 63 personal care homes with 2,250 beds in 1993. The average number of beds per facility was 35.7, about twice the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in West Virginia. Home care is not licensed but in 1993 there were 68 certified home care agencies.

CON/Moratorium

West Virginia had a CON for nursing homes from 1978 through 1993, adding a moratorium to it in 1987 which also remained in effect through 1993. In 1993 the CON/moratorium also covered hospital bed conversion, while a CON alone covered ICF/MRs and home health care. There was neither a CON nor moratorium for residential care. There were 2 CON applications for nursing homes in 1993, none of which were denied.

WEST VIRGINIA

Demographics

Percentage Population 65 and Over	15 % (US 12.7%)
Percentage Population 85 and Over	1.6 % (US 1.4%)

Nursing Home Facilities

Total Facilities	127
Total Beds	10797
Beds Per Nursing Home	85
Average Occupancy Rate	96.5
Beds Per 1000 Population:	
Age 65 and Over	38.9 (US 53.0)
Age 85 and Over	372.6 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	5.73 (US 6.2)
Expenditures Per 1000 Pop, 1992	$81,959 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	62
Total Beds	709
Beds Per Facility	11.4
Beds Per 1000 Population	0.39 (US 0.53)

Other Residential Care For Aged

Total Facilities	63
Total Beds	2250
Beds Per Facility	35.7
Beds Per 1000 Pop, Age 65+	8.1 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.29 (US 3.6)
Expenditures Per 1000 Pop, 1992	$1,870 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON & Moratorium
Hospitial Bed Conversion	CON & Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

WEST VIRGINIA

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employs a peer grouping by Number of Beds. The basic reimbursement method was adopted in 1981. Rates were set semi-annually beginning April and October and reported on a Calendar year. The preceding six month cost reports (Jan. to June and July to Dec.) were used for 1993. Inflation based on the CPI and Case-mix were used to trend rates. The minimum occupancy standard was set at 95%.

Adjustments

Two rate periods are used to set rates per year.

Cost Centers

Three cost centers were used for setting reimbursement rates in West Virginia: 1. Nursing, limited to beds peer 70th percentile; 2. Capital; and 3. Operating, with eight line items limited in one of two ways, by the peer group arrayed mean (throwing out the high and low) then re-average or 95% occupancy, depending on the line item.

Ancillary Services

Physical Therapy, Non-Prescription Drugs, Medical Supplies, Oxygen and Physician Services, were included in the rate within the appropriate cost center.

Case-Mix Adjusters

Case-mix was adopted 1979. West Virginia used its own patient assessment factors developed in the late 70's and MDS+ acuity measurement. Indirect and Direct Nursing Care was based on case-mix. Nineteen levels of care were provided.

Capital Costs

The value of capital was determined by a combination of factors: Appraisal, and a Rental Value. For capital-interest expenses, nursing facilities used the prevailing market rate. They have a Gross Fair Rental System. Appraisals were conducted with no maximum appraised value. They use a "model" facility standard methodology called Standard Appraised Value (SAV). A capitalization rate was established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land, building and equipment. The Band of Investment approach was used to blend the fixed income capital and the equity capital which produces a rate which may be changed semi-annually to reflect current money values. The band of investment sets a 75:25 debt-services to equity ratio. The interest rate was the base FNMA current at time of original indebtedness, modified for non-profit facilities.

Reimbursement Rate

The 1993 average reimbursement rate for West Virginia was $78.13, weighted by days of care.

Other Long-Term Care

West Virginia uses the same system for hospital-based as for free-standing nursing facilities, but a prospective facility-specific system without adjustments for ICF-MR, which averages almost three-times as high as for nursing facilities.

Home health is paid under Medicare principles, both RN and home health aide visits averaging the same ($54). There is no Medicaid coverage for residential care nor for adult day care, nor any separate Medicaid program for acute care.

WEST VIRGINIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$78.13
Percentage Rate Change From Previous Year	8.09%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	Preceding Six Months Cost Reports
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	95%
Case-Mix Adjusted	Acuity Measurement Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Appraisal and Rental Value
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Non-Prescription Drugs	Medical Supplies
Physician Services	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Facility-Specific (fee plus per diem)
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate (all facilities)	$202.04
Capital Reimbursement Determination (all facilities)	Standard Appraisal Value
Ancillary Services Included in Rate	
All Facilities	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies
State Facilities Only	
Private Facilities Only	Patient Transport, Oxygen

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$54.00
Average Reimbursement Rate, HH Aide Visit	$54.00

Other Residential Care For Aged

None

Adult Day Care

None

Sub-Acute Care

No Separate Program

WISCONSIN

Nursing Homes

The number of nursing homes in Wisconsin fluctuated between 1978 and 1993, reaching a high of 453 in 1986 before declining to 423 in 1993. The number of beds reached a high of 53,937 in 1985 before declining to 49,705 in 1993, a total decease of 837 beds since 1978. The total annual growth in number of beds is -1.66, one of only two negative growth rates in the country.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities grew from 40 in 1989 to 60 in 1992 but dropped to 58 in 1993. The number of beds increased from 4,114 to 4,520 between 1989 and 1992 but dropped to 4,317 in 1993. The 1993 ratio of beds per 1000 population, .86, was substantially higher than the national ratio despite the drop.

Other Residential Care

Wisconsin categorizes its residential care facilities by size - small (3-8 beds), medium (9-20 beds), and large (21 or more beds). There was a total of 1,341 facilities and 15,848 beds in 1993, up from 1,005 facilities and 12,513 beds in 1989. The average number of beds per facility in 1993 was 11.8, about 5 beds less than the national average.

Adult Day Care and Home Health Care

Adult day care is not licensed in Wisconsin (although facilities do get certified and must meet the standards of the Adult Day Care Association). The number of licensed home care agencies has been slowly increasing, growing from 174 in 1990 to 187 in 1992 to 202 in 1993.

CON/Moratorium

Wisconsin had a CON for nursing homes from 1978 through 1993. In 1981 the state added a moratorium, which remained in effect with the CON until being dropped in 1990. In 1993 the CON also covered ICF/MRs and home health care, while there was a moratorium on hospital bed conversion. There was neither a CON nor moratorium on residential care. There were 26 CON applications for nursing homes in 1993, only 1 of which was denied.

WISCONSIN

Demographics

Percentage Population 65 and Over	13 % (US 12.7%)
Percentage Population 85 and Over	1.6 % (US 1.4%)

Nursing Home Facilities

Total Facilities	423
Total Beds	49705
Beds Per Nursing Home	117.5
Average Occupancy Rate	91.5
Beds Per 1000 Population:	
Age 65 and Over	73.6 (US 53.0)
Age 85 and Over	603.6 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	8.93 (US 6.2)
Expenditures Per 1000 Pop, 1992	$123396 (US $92,314)
Adequacy of Bed Supply	Over Supply

Intermediate Care For Mentally Retarded

Total Facilities	58
Total Beds	4317
Beds Per Facility	74.4
Beds Per 1000 Population	0.86 (US 0.53)

Other Residential Care For Aged

Total Facilities	1341
Total Beds	15848
Beds Per Facility	11.8
Beds Per 1000 Pop, Age 65+	23.46 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	202
Agencies Per 1000 Pop, Age 65+	0.3 (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	2.89 (US 3.6)
Expenditures Per 1000 Pop, 1992	$17,982 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	CON Only
Hospitial Bed Conversion	Moratorium Only
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	CON Only
Day Care Agencies	No CON nor Moratorium

WISCONSIN

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in the early 80's. A state fiscal year was used to set annual rates beginning July 1. The earliest cost report used for FY1993 was 1991. Inflation based on SNF market basket was used to trend rates. The minimum occupancy standard was set at 91%.

Adjustments

No adjustments to the initial rates were made.

Cost Centers

Seven cost centers were used for setting reimbursement rates in Wisconsin: 1. Direct Care, limited to 110% of the median (regionally adjusted); 2. Support Services, limited to 102% of the median; 3. Administration and General limited to 102% of the median; 4. Cost Share and Incentive Payment; 5. Fuel and Utilities, limited to 120% of the median (regionally adjusted by heating degree days; 6. Property tax; and 7. Capital. A comprehensive limit on operating cost is 102% of the median.

Ancillary Services

Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, and Oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Wisconsin. Patient characteristics were used to set rates, based on an acuity measurement. The rates for special patient characteristics were overall- facility based. The Direct Nursing portion of the rate was adjusted. Eight levels of care were provided.

Capital Costs

The property payment (Gross Fair Rental System) was based upon an equalized value of a facility's buildings, relating to ownership and/or rental. It was a target amount based on a service factor that includes depreciation; interest on plant asset loans; amortization of construction-related costs; lease and rental expenses; and property and mortgage insurance. Systematic reduction of debt was used for interest and principal payments. The maximum term did not exceed 40 years. Annual principal payments or deposits were made to an interest bearing, segregated account resulting in repayment of debt at loan maturity. Otherwise 30 years were used to amortized and interest income was then offset against allowed interest expense. Refinancing was allowed but limited to original loan plan. Interest was limited to same as original loan plus cost of asset acquisitions allowed in refinancing. Allowable Property-Related Expenses were limited to 15%. Appraisal were used for Medicaid rate purposes with interest limited to 6.9% (undepreciated) and 8.9% (replacement cost). These figures were also the rental factors.

Reimbursement Rate

The 1993 average reimbursement rate for Wisconsin was $73.41, weighted by days of care. Operating cost totaled $67.54, and Capital was $5.87.

Other Long-Term Care

Wisconsin uses the same system for hospital-based as for free-standing nursing facilities, and the same system for private ICF-MR, with rates averaging about 30% higher than for nursing facilities. For state ICF-MRs, a retrospective method is used that results in rates three-times as high as in nursing facilities. Home health visits are paid using Medicare principles with state alterations involving flat rates, twice as high for RN visits ($78.50) as for home health aide visits ($37). Adult day care is covered under waiver, using retrospective patient-specific methodology.

WISCONSIN

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$73.41
Percentage Rate Change From Previous Year	-2.37[1] %
Peer Groupings	None
Year of Cost Report to Set Rate	1991
Inflation Adjustment	SNF Market Basket
Minimum Occupancy in Rate-Setting	91%
Case-Mix Adjusted	None (patient characteristics were used)
Capital Reimbursement Determination	Rental Value (see text)
Ancillary Services Included in Rate	
	Medical Supplies Durable Med. Equip. Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	
State Facilities	$225.00
Private Facilities	$95.67
Capital Reimbursement Determination (all Facilities)	Historic Cost
Ancillary Services Included in Rate	
State Facilities	Included All Ancillary Services
Private Facilities	Non-Prescription Drug Medical Supplies Durable Med. Equip.

Home Health

Method	Medicare Principles/Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$78.50
Average Reimbursement Rate, HH Aide Visit	$37.00

Other Residential Care For Aged

None

Adult Day Care

Method	Retrospective Patient-Specific
Program	2176 Wavier
Facility Type	Social, Day Health, and Dementia/Alzheimers Disease
Rate Range by Clients	
Aged, Physically & Mentally Disabled, AIDS/ARC	$20-38/Day
Developmentally Disabled	$7-15/Day

Sub-Acute Care

No Separate Program

[1] Based on 1992 average rate of 75.19.

WYOMING

Nursing Homes

The number of nursing homes in Wyoming remained constant at 27 from 1978 to 1984, increased to 37 in 1992, and then decreased to 35 in 1993, the third fewest number of nursing homes in the country. The number of beds grew slowly from 1,962 in 1978 to 2,098 in 1983, increased rapidly to 3,555 in 1992, then dropped to 3,216 in 1993. The 1993 ratio of beds per 1000 population aged 65 and over was 62.7, higher than the national ratio.

Intermediate Care for Mentally Retarded

Wyoming had 1 ICF/MR facility with 90 ICF/MR beds in 1992 and 1993. This beds per facility ratio is about 4 times the national average, while the ratio of beds per 1000 population (.19) was substantially lower the national average.

Other Residential Care

Wyoming licenses residential care in board and care homes. In 1993 there were 30 residential care facilities with 617 beds, the fewest number of facilities in the country and the third fewest beds.

Adult Day Care and Home Health Care

Adult day care is not licensed in Wyoming. Home care is not licensed but in 1993 there were 46 certified home care agencies.

CON/Moratorium

Wyoming had a CON for nursing homes between 1978 and 1984 but dropped it in 1985 and has had neither a CON nor moratorium from 1985 through 1993. In 1993 there was neither a CON nor moratorium on hospital bed conversion, ICF/MRs, residential care, or home health care. There has not been a CON or moratorium on home health care since at least 1978.

WYOMING

Demographics

Percentage Population 65 and Over	11 % (US 12.7%)
Percentage Population 85 and Over	1.2 % (US 1.4%)

Nursing Home Facilities

Total Facilities	35
Total Beds	3216
Beds Per Nursing Home	91.9
Average Occupancy Rate	86.7
Beds Per 1000 Population:	
Age 65 and Over	62.7 (US 53.0)
Age 85 and Over	592.9 (US 490.5)
Medicaid:	
Recipients Per 1000 Pop, 1992	4.87 (US 6.2)
Expenditures Per 1000 Pop, 1992	$69,339 (US $92,314)
Adequacy of Bed Supply	Adequate Supply

Intermediate Care For Mentally Retarded

Total Facilities	1
Total Beds	90
Beds Per Facility	90
Beds Per 1000 Population	0.19 (US 0.53)

Other Residential Care For Aged

Total Facilities	30
Total Beds	617
Beds Per Facility	20.6
Beds Per 1000 Pop, Age 65+	12.03 (US 19.6)

Adult Day Care For Aged

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65+	Not Licensed (US 0.10)

Home Health Care Agencies

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65+	Not Licensed (US 0.37)
Medicaid:	
Recipients Per 1000 Pop, 1992	1.84 (US 3.6)
Expenditures Per 1000 Pop, 1992	$1,485 (US $19,161)

Certificate of Need (CON) or Moratorium Program

Nursing Home	No CON nor Moratorium
Hospitial Bed Conversion	No CON nor Moratorium
Residental Care Beds	No CON nor Moratorium
Home Health Care Agencies	No CON nor Moratorium
Day Care Agencies	No CON nor Moratorium

WYOMING

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1989. A facility fiscal year was used to set annual rates, most coinciding with the state fiscal year beginning July 1. The 1992 Cost report or the most recent settled cost report was used. Inflation based on the GNPI was used to trend rates. The minimum occupancy standard, set at 90%, was used for capital only.

Adjustments

Adjustments to the initial rates were made upward one time for all facilities due to appeal. The rates were adjusted upward retroactively seven time for twenty percent of the facilities due to appeal.

Cost Centers

Three cost centers were used: Health Care, limited to 140% of the median; Operating, limited to 120% of the median; and Capital Cost. A comprehensive limit on operating costs was the cap of the median.

Ancillary Services

Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Durable Medical Equipment, Patient Transportation, and Oxygen, were included in the rate. They were in the Health Care component.

Case-Mix Adjusters

No case-mix adjusters were used in Wyoming. One level of care was provided.

Capital Costs

The value of capital was determined by historic cost. For capital-interest expenses, nursing facilities used the actual interest expense. Refinancing, Renovation and Rental Costs and Leases were allowable costs. A cap was placed on allowable interest rates. The straight line method and the American Hospital Guidelines were used for depreciation.

Reimbursement Rate

The 1993 average reimbursement rate for Wyoming was $73.06, weighted by days of care. Operating total $14.00 and Capital was $6.00.

Other Long-Term Care

Wyoming uses the same system for hospital-based and free-standing nursing facilities, and the same approach for ICF-MR, which has average rates three-times nursing facility rates. Home health uses a fee schedule with flat rates 70% higher for RN visits ($60) than for home health aide visits ($35). Adult day care is reimbursed under waiver using a prospective class method.

WYOMING

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$73.06
Percentage Rate Change From Previous Year	3.40%
Peer Groupings	None
Year of Cost Report to Set Rate	1992 or Most Recent
Inflation Adjustment	GNPI
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusted	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies
Non-Prescription Drug	Oxygen
Durable Med. Equip.	Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

IFC-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$230.30
Ancillary Services Included in Rate	

Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies
Non-Prescription Drug	Patient Transport
Oxygen	

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$60.00
Average Reimbursement Rate, HH Aide Visit	$35.00

Other Residential Care for Aged

None

Adult Day Care

Method	Prospective Flat Rate
Program	2176 Waiver
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill, AIDS/HIV
Flat Rate	$5/Hour (up to 8 hours per day)

Sub-Acute Care

Not Separate Program

*U.S. G.P.O.:1995-386-897:33451

Today's Changes
Tomorrow's Trends

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